Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 42501 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8: 75 AM 70 December 009 Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Nursing 4115 Wheaton Montgomery 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under Social Security Number **Funeral** Days Hours Min. (Month, Day, 1 🗆 M 2 🕟 Yrs. Korea Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Tes 2 No attsville 10f. Zip Code ō 10e. Street and Number 10g. Citizen of What Country? 23a 20784 6821 1-reeport or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 2 2 Yes permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Asian 3 ☑ Widowed 4 ☐ Divorced Specify. "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) House w omes 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tracence. FreeDort HVaHSVILL nona 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Crepration 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furneral Service Licen 22. Name and Address of Facility Guiltox 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's disease or condition resulting in death) vears -Medical Due to (or as a consequence of) Examiner mentia lears Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit llation that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this conditions. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 **②** No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 20 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 No Hospital Other: 1 Tes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 21033 December 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dyoung MD 13000 Georgia

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 42502 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Examiner Name (if not institution, give street and number) 4c. County of Death Social Security Number 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months Hours Min. 04/05/1925 N.Carolina Director 243-24-1831 1 MM 2 □ F 87 Yrs. Usual Residence of Decedent ir then "neturel", or Items 23e or 28e-f show the Wedgel Exeminer must be notified at 10b, County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Maryland Baltimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 3801 Schnaper Drive #334 21133 USA filed within 72 hours after death all Hyglene. Jother then "neturel", or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th grade College (1-4 or 5+) ADT Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H litem 27 is merked of rother treumetic ever should be Henry Cooper Ada Bobbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 permit. Page 1 and 2 shr Department of Health an Importent: If Item 27 Is eny Injury or other treur Anne M. Cooper/Wife Schnaper Drive #334 Randallstown MD. 3801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/03713 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Vet. Cemeter Owings Mills, MD. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore,MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospitel or Attending Physicien: The law requires that the death certificate be executed 24 hours. Her death.

France of the first ordinate has have almost be the continued of the first ordinate has have almost be the continued of the first ordinate has been almost be the continued of the first ordinate has been almost ordinate ordina Cause (Disease or injury attending physician and for use as the burlai-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown . Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No funeral director, Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Hospital Other: 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicidè Investigation completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice@ Northwest Hosp tal Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 217-50-2564 Director 1 M 2 F 05/08/1947 Maryland Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23e or 28a-f shov 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23e or 28a-f sho event, the Medical Examiner must be notified et Director Baltimore Pikesville Maryland t Ves 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Warren Park Drive Apt.B1 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade College (1-4 or 5+) Clerk Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked o ည Thomas Bailey Frances Cosby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Park Drive #B2 Pikesville,MD.21208 Claudette Curry/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 KI Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) King Memorial Park 12-29-12 Windsor Mill, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Lie lex 240 Reisterstown Rd.Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Prysician/ Ada careinana rnknown disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physiclan and s the buriat-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) g Unknown 9 Ulnknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No Yes 2 KNo 1 Tes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 | Residence 6 Stather (Specify) In nahent 1 🗌 Yes ပ္ 2 2 KNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of nospice 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending s after death. 2 Accident 1 Yes 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completely fi 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 47683 12/23/12 Thymore Mille MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raymon Miller Box 1525 owings 21117 Milk

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42504 = State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day 2.2 Year Physician/ 08:28AM CROMWELL BERTA 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE BALTIMORE AMARITAN HOS PITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Hours Country) Director 1 🗆 M 2 💢 F show or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö or than "natural", or items 23a or the Medical Examiner must be Funeral St filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Tyes 2 No Specify If Yes, Give Year or Dates Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) College (1-4 or 5+) 145 tod of Health and Mental Hygie f item 27 is marked other r other traumatic event, th Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hv. Important: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) /elma Saliahtry Essex 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 2013 Fore Owinas Mill, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HYPOXIA DAYS disease or condition resulting in death) Medical Examiner IN TERSTITEAL PNEW MONI Sequentially list conditions, Examiner cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed MONTHS PULMONARY FIBROSIT ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical YEARS BESTOS Exposure Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No

9 Unknown 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 X No 2 1 🗌 Yes Date of injury 2 ER/Outpatient 3 DOA

28b. Time of 28b 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1/XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) P27613 December 22, 2012

State Registrar DHMH 17 Rev 06-2011 RAVEN

BLVD, BALTIMORE

5601 LOCH

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAIAL

RISHIKESH

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 16 2-12 08.30 AM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death MANOR CATON Baltimore enesis If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country Director 1 X M 2 □ F 959 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Prestor 21202 E. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black f Yes, Give Year or Dates. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+))iSûbleo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) arrie Powel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UCTAVIA Middle River, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21262 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Renal railure Records, Completed 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifiel 10062634 21,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10796 ELUMBIA Aw AN MD 21044 MATERN HICKORY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6 45 PM 2012 CRESPO DE DETIZ PECEMBEL Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** COUNTY COLUMBIA HONARD GENERAL COUNTY Howard Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 580-64-5865 77 Director 1 🗆 M 2 🗶 F Sept. 3,1935 Puerto Rico Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State by Funeral Director the Medical Examiner must be notified 1 ☐ Yes 2 🙀 No Maryland Jessup Howard 10f. Zip Code 10g. Citizen of What Country? or ? 10e. Street and Numbe 23a 20794 USA 8309 Firewood Court "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Puerto Rican Specify: Hispanic 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>the</u> once. Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miguel Crespo Anastasia Guasp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8309 Firewood Court Jessup, Maryland 20794 Noel J. Ortiz/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 12/28/2012 Baltimore, Maryland Metro Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility remation Society of Maryland, Inc Custer Signature of Funeral Service Lice 299 Frederick Road Baltimore, Maryland 21223 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ STA **PENAL** DISEASE END Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events as the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknow Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, To Be examiner? Other: 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 28a. Date of injury 27 Manner of Death Certificate: (Month, Day, Year, iniury work?
1 Yes 2 No Natural 5 Pending Investigation Could not be Accident 24 hours after deat Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hounded to the second to the secon 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner start (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D00631 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MECOLUMBIA MO 21044 ANIRUDH CEDAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 3 2013 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 37PM Month Physician/ lecember 28 9019 Michael Cole Lee Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner tranklin HIMORE osedo If Under 8. Date of Birth 9. Birthplace (State or Foreign al Security Number Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 215-54-2764 Director 1 ▼M 2 □ F 1953 Maryland Nov. 13, permit. Paga 1 and 2 should ba flied within 72 hours aftar daath with the Maryland Department of Health and Mantal Hygiane. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Madical Examinat must be nothing at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Nottingham Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21236 9219 Carlisle Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. چ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Messenger Messenger Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Dorothy Jett John Cole Η. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 902 Meadow Ridge Court, Bel Air, Maryland 21014 Steven Cole / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/31/2012 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland In 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1, Enter the disease, or complications shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the Hospital or Attanding Physician: The law raquiras that the death cartificata be axecuted baan signad by tha attanding physician and should be detached for usa as tha burlal-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autoosy death? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funaral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending within 24 hours aftar daath.

To the Funeral Director: Ai complataly filled in by tha fu 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year December 24 201 Corbett Physician/ Kenneth 1530 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Futurecare Lochearn If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funera (Month, Day, Year) 220-76-3394 56 Yrs. Director 1 X M 2 □ F 01/15/1956 Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Marylend th and Mental Hyglene. 27 is merked other then "neturel", or items 23e or 28e-f show treumatic event, the Medical Example must be notified it. 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State Director N/A MD Baltimore 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4800 Seton Drive 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 ☑ Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black 3 ☐ Widowed 4 ☐ Divorced rres, Give Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Disabled UNK Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ပ္ Clarence Corbett Emma Williams Department of Health and Important: If Itam 27 is meny Injury or other treumance. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Emma Corbett (Mother) 3030 Walbrook Ave. Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1/8/13 Landsdowne, MD 4 Donation 5 Other (Specify) Zion ²² Joseph H. Brown, Jr. Funeral 2140 N. Fulton Ave. Baltimore, 21. Signature of Funeral Service Licenses Home PA MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Physician/ 515 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner neumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physicien end I for usa es the buriel-trensit Hospital or Attanding Physician: The lew requires thet the daeth certificete ba executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy After this certificate has bean signed by the etter funeral director, page 2 should ba deteched for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 2 No ours efter death. erel Director: After this certifica filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 6 Other (Specify) Other: Hospice 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ∐ Yes 2 ∐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours e Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00053337 December 29 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie Boulvard 6935 AVIATION

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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2013

/ 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 THOMAS P. CROKE 9 50 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sauare Baltimore FRANKLIN Rosedale Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 213-88-5749 49 Director 1 🖾 M 2 🗆 F 8/5/1963 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE WHITE MARSH 1 Yes 2 XNo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5213 BANGERT ST 21162 **IISA** 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Warried 2 Married ₽ 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MUSICIAN ENTERTAINMENT Be Maryland permit. Pege 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRANCIS CROKE MARIA FURST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5213 BANGERT ST WHITE MARSH, MD 21162 MARIA CROKE Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MORELAND CEMETERY 12/31/12 BALTIMORE, MD . Signature of Funeral Service License 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME 9705 BELAIR RD NOTTINGHAM. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ multi Failure disease or condition resulting in death) organ Medical Due to (or as a consequence of): Examiner End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): • Hospital or Attanding Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attanding physician and elety filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): DISCase End LIVER sician and burial-trans that initiated events resulting in death) Last Physician/Medical Se PSIS Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 [1] No 1 🗌 Yes 2 3 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) SELIALL MOHAMMAD 12-26-2012 RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR Balto md 21237 SoHail mohammad 31. Date filed (Month, Day, Year) 32. Registrar's Signatu Registrar

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DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2°012 Dec.30 Melvin L. Conley 0104 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richie Hospice Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Months Min (Month, Day, Year) 216-74-2238 47 Director 1 DM 2 DF Jan.1,1965 MD Usual Residence of Deceder permit. Pege 1 and 2 should ba filed within 72 hours efter deeth with tha Merylend Department of Health end Mental Hyglane. Importent: if item 27 is merked other then "neturel", or iteme 23a or 28e-f show the jury or other treumetic event, the Medical Examiner must be notified 31 once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1, Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1406 W. Franklin St. 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Manital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer-Vulcanhart Co. Machinery 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David H. Conley Margaret Tates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Conley (mother) 1406 W. Franklin St. Balto, Md. 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Jan.4,2013 Balto, MD Zion Cem 4 ☐ Donation 5 ☐ Other (Specify) Mt. 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Calvin B. Scruggs Funeral Home
1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Month Immediate Cause (Final Hepatocellulas Carcinin a Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlai-transit that initiated events resulting in death) Last Due to (or as a consequence of): To Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy
Use Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hepatitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Alcoholism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an performe ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ð Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Natural Accident (Month, Day, Year) 5 Pending Division Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) use of death (Item 23a) (Type, Print) , P21 N. Eutow 5t. #30 1, Kenneth YIM MD

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 3 2013

Division of Vital completely the To the within To the

> State Registrar

29a. Certifier

(Check

only one)

29b. Signature and title of certifie

alini

31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 3 2013

9512 N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

t

🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Rebecca Ann C	oug		ate of Maryla	nd / Depa		f Health and		Hygiene		12 4251
Physici Medical Exami		1. Decedent's Name (First, Midd Rebecca Ann Co						2. Date of Deat Month December		3. Time of Death 1245 hrs
		4a. Facility Name (if not institution 215 N. Atholgate Land	, •	mber)		4b. City, Town, or Baltimore	Location of Dea		4c. County of	Death
Funeral Director		5. Social Security Number UNK	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year Months Days		lin		9. Birthplace (State or Foreign Country Maryland
d tow any		Usual Residence of Decedent 10a. State 10b. County Manual and			Town or Locat					10d. Inside City Limits 1 XXYes 2 No
th the Maryland 23a or 28a-f sho	Direct	Maryland 10e. Street and Number 215 N. Atholgat	e Lane Apt		Imore C	10f. Zip Code 21229			og. Citizen of Wha	•
r death wi	by Funeral	3 Widowed 4 Div	arried Armed Fo 1 Yes rorced If Yes, Give Year or Dates:	2 X No	If Y	es Decedent of His es, specify Cuban Yes 2 No	Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - White, Specify:	American Indian, Black, etc. White
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	Completed t	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12th	College (1-			nt's Usual Occupat ost of working life.			16b. Kind of Busi Food Inc	
21215-0036 vald be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be	17. Father's Name (First, Middle, Edward Cougher)	our		Louis		Catheri	ne (First, Middle, M ne Grass	0	
rre, MD 2 s I and 2 should of Health and M If item 27 is m	ဥ	19a. Informant's Name/Relations Cathy McGowan 20a. Method of Disposition		20b.	5934		ve., Ba	r Rural Route Num 1timore, I Date	Maryland	
Baltimore, permit. Pages I as Department of Hes Important: If ite		1 X Surial 2 Cremation 4 Donation 5 Other So 21 Signature of Funeral Service	pecify: Licensee	m State Ga	rdens 0	nerplace) f Faith	Mem'l D	ec.28,20	l2 Roseda	ale,Maryland OF LANSDOWNE
Physician /Medical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	complications that ca on each line. a. Multiple Inju	ries	. Do not enter th					Maryland 21227 t Approximate Interval Between Onset and Death
	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsass or Injury that initiated events resulting in death). Last	b. Due to (or as a of the control of	consequence o	f):	~				
oe executed ician and irial - transit	dical Ex	UNPENDED	d. AMENDED							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								
ords, P.O. Be we requires that the disbeen signed by the should be detached	Ď	Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	nderlying cause g	ven in Part I.	1 Yes	2 No 3	te to the cause of death? Probably 4 Unknown ere autopsy findings available or to completion of cause of
Vital Recol	e Completed	25. Was case referred to medical				26.Place	of Death (Chec	autops perform 1 Yes 2 k only one)	med? dea	ath? Yes 2 No
Division of Vital Records, rai or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	ion: To B	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pend	28a. Date o	patient 2 f Injury Pay Year) 2012	ER/Outpatient 28b. Time of Ir 0645 hrs	njury 28c. Injur	Other Nurs y at Work? es 2 No		Residence 6 🗸 ow injury occurred aulted	
Division To the Hospital or Attent within 24 hours after death To the Functal Director:	ertification:	2 Accident Invest 3 Suicide 6 Could	tigation 28e. Place	of Injury - At ho Multi-Famil		et, factory, office bu		or Town, St		or Rural Route Number, City Baltimore, MD
To the Host within 24 ho To the Func completely f	edical C	Conden only	nysician: To the best niner:On the basis of and manner sta	examination a						
2 hr	Σ	29b Signature and title of certifie 30. Name and address of person	u	of death (Item	7 23a)	29c. License O.C.N			29d. Date signed December 2	(Month, Day, Year) 1, 2012
		· ·	Assistant Medica		900 W. B	altimore Stree	et, Baltimore	e, MD 21223		
St Regist		JAN 0 3 2013	Server 1	A. A	bake	_				
DHMH 17 Rev 1/20	001		_		ORIGINAL	L				OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Roy James Chase	1- For State	tate of Maryla	nd / Department <i>Certificate</i>		d Mental Hy			12 4251
Physician/	Registrar 1. Decedent's Name (First, Midd	dle,Last)	Continuato	Or Dodin		2. Date of Death		3. Time of Death
Medical Examine						Month December	Day Year 16, 2012	1941 hrs
	4a. Facility Name (if not instituti Peninsula Regional N		nber)	4b. City, Town, or l Salisbury	Location of Death		4c. County of I	
Successi	Social Security Number		7. Age (In yrs. last birthday		If Under 24Hrs.	8 Date of Birti		9. Birthplace (State or
Funeral Director	unknown	1XM 2F		Months Days		7/20/5	` F	Foreign Country) Maine
	Usual Residence of Decedent	IZX W Z	57	115.		1/20/3	3	
, any	10a. State 10b. County		10c. City, Town or Lo	ecation				10d. Inside City Limits
land f show	MD Wice	omico	Salisb	ury				1 X Yes 2 No
the Maryland a or 28a-f sh tilfied at once	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	: Country?
th the 23a o				21804	i- O-i-i-2 / O-		SA	Associate Indian Disele
r items 23	1 X Never Married 2 N	Married Armed For	ces?	Was Decedent of Hisp If Yes, specify Cuban,			White, e	American Indian, Black, etc.
fter de	3 Widowed 4 Di	1 Yes vorced If Yes, Give Year	XIX No	Yes 2X No	specify:		Specify: V	white
ours aft		ecify only highest grade		dent's Usual Occupation			16b. Kind of Busir	
16 n 72 h nan "p	Elementary/Secondary (0-12)) College (1-	4 or 5+)		DO NOT USE TELL	ou)		
5-0036 lied within 72 hour Hygiene. t other than "matu the Medical Exar Completed	17. Father's Name (First, Middle	e Last)	unk	nown I	18. Mother's Name	(First Middle M	unkn	own
215. 215. ntal Hy riked of ent, th							,	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fah. 27 is marked other than "natural", or items 23a or 28a-fah. To Be Completed by Funeral Director	19a. Informant's Name/Relation	ship (Type, Print)		iling Address (Street				
MD d 2 sho lith and lith and	Faye Woodcoo	k-Murray		Margin St				
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 X Crematio	n 3 Removal from	m State crematory o	position (Name of cem rother place)		Date	20c. Location - C	ity or Town, State
Baltimore, permit. Pages I an Oppartment of He Important: If ite injury or other tr	4 Donation 5 Other S	Specify:	Atlant	ic Cremat	tory12/	22/12	Glen B	urnie MD
Bal permit Depar Impo	21. Signature of funeral Service	Licensee	2	2. Name and Address 7221 Gray	yburn D	rman F	uneral Burnie	Service MD 2161
Physician	23a. Part I. Enter the disease, o							Approximate Interval
/Medical	failure. List only one cause Immediate Cause (Final disease		1 and Tramad	ol Intoxic	ation			Between Onset and Death
Examiner	or condition resulting in death)		consequence of):					
	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a o	consequence of):					
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ox 68760 ath certificate battending physior use as the busican/Me	23b. Was decedent pregnant in t past 12 months?	I I LIVE DII	at at time of death	Fetal death 3	Ectopic pregna	ncy	Month	Day Year
Box 6876(e death certificate the attending phy ed for use as the b	1 Yes 2 No 9 Un		3	Other (Specify)			MC	
of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate I After this certificate has been signed by the attending physimeral director, page 2 should be detached for use as the but To Be Completed by Physician/Me	Part II. Other significant condi	tions contributing to	death but not resulting in the	ne underlying cause giv	iven in Part I.			te to the cause of death?
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be ettilication: To Be Completed	1 Natural 5 Pen	ding fd 12	Day, Year) -16-12 fd 7:	1 1 1	es 2 X No		took dru	
IVISION or Atteno after death Director: I in by the	2 X Accident Inve	Sugation	of Injury - At home, farm, s			28f. Location (St	reet and Number	or Rural Route Number, City
Division spital or Attend nours after death noral Director: filled in by the Certificati		ermined (Specify)	Multi-Fami	ly Apt.	, j	Salisbur	y,MD.	Church St.
	29a Certifier 1 Certifying P	-	of my knowledge, death or examination and/or invest					
To the Howithin 24 To the Roughletel	29b. Signature and title of certific	and manner sta		29c. License		o une, date a		(Month, Day, Year)
	0-27.			O.C.N			December 17	
4	30. Name and address of persor	n who completed cause	of death (Item 23a)			}		
4	Donna M. Vincenti, M			00 W. Baltimore	Street, Baltim	ore, MD 212	223	
State Registrar		32. Reg	istrar's Signature					

12-09777 Robert Diggs

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2012 42516

		1- For State Registrar		Cer	tificate o	Death					g. No.		
Physici	_	Decedent's Name (First, Midd	fle,Last)							ate of Deat		Year	3. Time of Death
dical Exami	1 Note 1 - 20 2043 - 55 1 091/ NIS							0917 hrs					
		4a. Facility Name (if not instituti		I number)		4b. City, Tow	n, or Lo	ocation of D	eath		4c. Cou	inty of Death	
		832 Jaydee Avenue	on, give on our and	,		Dundall					Balti	more Cou	nty
				7. Age (In yrs. la	at hintholous	If Under 1	Vear	If Under 2	4Hrs 8	Date of Bir	th/MM/DD/	7777 9. Birt	hplace (State or
Funeral		Social Security Number	6. Sex	, ,	ist birthday)	Months		Hours			5/197	Caraia	Maryland
Director		212-90-4084	1X M 2	_F 40	Yı		- '			J 4 / T C	7/17/	2 00	untry)
_		Usual Residence of Decedent											10d. Inside City Limits
tuy		10a. State 10b. County		10c. City,	Town or Loca	ation							
_ 4	١. ١	Maryland 1	Baltimo	re Dund	lalk								1 Yes 2 X No
Maryland 28a-f show any d at once.	<u>5</u>	10e. Street and Number			-	10f. Zip Co	xde			1	0g. Citizen	of What Coul	ntry?
Mar.	Director										TT C 2		
72 hours after death with the Maryland n "matural", or items 23a or 28a-f sho sal Examiner must be notified at once.		832 Jaydee A				212					USA	Daga Amor	ican Indian, Black,
with with be no 2.	Funeral	11. Marital Status		Decedent Ever in U. d Forces?	S. 13. W	as Decedent Yes, specify (of Hisp Suban.	anic Origin Mexican, P	? (Specify uerto Rica	/ Yesor No ın, etc.)		White, etc.	icali ilidiali, black,
eath r iter	ട്ട്	1 Never Married 2 X	Married 1 X Y		"							77. 7	1
rer de	띤	3 Widowed 4 D	ivorced If Yes, Give	Year	1	Yes 2X						cify: Bla	
ırs af t ura l	b	15. Decedent's Education (Sp	ecify only highest	grade completed)	16a Decede	ent's Usual Oc	cupatio	on (Give kin	d of work	done		of Business/	
2 hou	Completed	Elementary/Secondary (0-12	Colleg	ge (1-4 or 5+)		most of working	-						e County n Center
36 in 7.	ם	12th grade			corre	ction	аı	OIII	cer		Dece	SILCTO.	n center
with with Mer t	E	17. Father's Name (First, Middl	e Last)			_	1	8.Mother's	Name (Fir:	st, Middle,	Maiden Sur	name)	
Hys Hys	Ö	John Brando						Carr	ie M	.Nel	son		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	19a. Informant's Name/Relation			19b Mail	ng Address						r Town, State	e, Zip Code)
hould Made is in	To												nd 21 <u>222</u>
MD d 2 shoulth and in 27 is		Cheronda Dig	gs/Wife	Look		osition (Name		etery	Da	ate	20c. Loc	ation - City or	Town, State
Hea Hea		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Pemos		crematory or		OI CEII	etery,	01/0	4/20	13	,	
ages nt of ethe				Ga	rriso	n Fore	est	Vet	.Cem	eter	wo w	ings	Mills,MD.
ti P	1 3	4 Donation 5 Other 21. Signature of Funeral Service	Specify: ce-Licensee										neral Home
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Nornfall Hygiens. Important: If item 27 is marked other than "matural", of injury or other traumatite event, the Medical Examiner.			1	1	4:	210 Be	ela	ir Ro	d, Ba	ltim	ore N	Maryl	and 21206
	-	23a. Part I. Enter the disease,	or complications th	nat caused the death	Do not ente	r the mode of	dvina.	such as car	diac or res	spiratory ar	rest, shock,	or heart	Approximate Interval
Physician / Medical		failure. List only one caus	se on each line. 📗	rowning a	na Ioi	eign o	oay	ODSL	racti	LUG U.	istal		Between Onset and Death
Examine		Immediate Cause (Final diseas	se a <u>trach</u>	ea compli	cating	Multi	<u>p1e</u>	Scle	rosis				1
ZAGIIIII	1	or condition resulting in death)	Due to (or	as a consequence of	of):								
		Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):											
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cuted and transit	۱ä	events resulting in death) Las	d										
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760, icate be physical the burn	Ž	IF FEMALE: 23b. Was decedent pregnant in		23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance					oregnancy				
688 ertifi ding		past 12 months?		regnant at time of de	a atha								
Box 68's death certificate attending	S:	1 Yes 2 No 9 U		Jnknown	2	Other (Speci	<i>y</i> /	-					
de the	3	Part II. Other significant con-			resulting in th	e underlying (ause o	iven in Par	t I.	23e. Did	tobacco use	contribute to	the cause of death?
that th		Part II. Other significant con-	and the continue	ing to doda. Dat not		, ,	·			1 \ Y	es 2 N	lo 3 Pro	obably 4 🗹 Unknown
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required the state of the state	ete										psy	prior to	autopsy findings available completion of cause of
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 24 ZO (2 440 PM Dorothy I. Dunkle Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death FRANKLIN Sauare Baltimore HOSPITal Rosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | November 4, 1916 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Fall River, Mass. Director 212-03-1749 1 □ M 2 📆 🗏 96 permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "neturel", or items 23e or 28a-f show the hygling or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County O roth y 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1XXX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21211 United States 3838 Roland Ave Apt# 1008 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 VNo If Yes, Give VN Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Specify: White 3 1 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Margaret Burns George H. Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7259 Pommel Drive Eldersburg, Maryland 21784 David Dunkle / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 5 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/29/2012 Pikesville, Maryland Druid Ridge Cemetery Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ shock emic POVOI Medical resulting in death) Due to or as a consequence of: Examiner AOTTIC Aneur SM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Drie to for as a consequence offi the Hospital or Attending Physicien: The law requires that the death certificete be executed y pertension that initiated events Due to (or as a consequence of): resulting in death) Last ettending physicien for use as the burie Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year the 9 Unknown cate has been signed by pege 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funerel Director: After this certificate I letely filled in by the funeral director, peg performed' 1 ☐ Yes 2 ☐ No å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funel completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 28 73726 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere 9600 Alex FRHMAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 Physician/ DECEMBER 2012 RAYMOND WALTER DOBRZYKOWSKI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 1 X M 2 □ F 89 215-16-5093 AUG. 2, 1923 MARYLAND Usual Residence of Decedent show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MARYLAND ROSEDALE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 end 2 should be filed within 72 hours after death with t Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be Funeral 4511 A WHITE MARSH RD. 21237 U.S.A. Dobrzykowski, Raymond 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedent Ever Armed Forces? 1

Yes 2

No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 TH. GRADE POSTAL CARRIER POST OFFICE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DOBRZYKOWSKI SOCHA STELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4511 A WHITE MARSH RD., BALTIMORE MD LORRAINE DOBRZYKOWSKI/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 12/27/2012 GLEN BURNIE MD 21. Signature of Funeral Survice Ucensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC 9705 BELAIR ROAD BALTIMORE . INC. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cellulitis disease or condition one day Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): attending physician and I for use as the burlal-transIt the Hospital or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death ed by the al 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed' 1 ☐ Yes 2 ☑ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√0 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6535 N. Charles Bohne 32. Registral's Signal in State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42519 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alan Charles Dausinger Month 2012 01:40 Dec. 27 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford County Examiner 4b. City, Town, or Location of Death Upper CHesapeake Medical Center Bel Air Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 213-66-7780 Director 1**X** M 2 □ F 57 Maryland oct. 26, 1955 ?7 Is marked other than "natural", or items 23a or 28a-f shov treumatic event, he Madical Examiner must be notified at 10b Count 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director PA 1 Yes 2 No Lancaster County Peach Botton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 17563 321 Peters Creek Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 █ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Francis Scott Key Bridge Supervisor Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked c Bert Dausinger 2 Edha Keen of Health and Mer of Health and Mer fitem 27 Is mark rother treumatio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
321 Peters Creek Rd., Peach Bottom, PA 17563 Beverly Dausinger (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 12/31/2012 Parkville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Bel Air 3 Namort Drive, Forest Hill, Maryland 21050 Leza Scere of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any I. a. Ing I. imm. cial-cause. Enter Underlying Cause (Disease or injury that initiated events Don to for as a consequence off law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Cher (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ To the Hospital or Attending Physi within 24 hours after death.
To the Funeral Director: After this c completely filled in by the funeral dir 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 \square Pending 1 Tes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and little 29d. Date signed (Month, Day, Year) D0057 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barrueto 500 upperchesopeate Drive Bel Air MD Fermin 31. Date filed (Month, Day, Year) State JAN 0 3 2013 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Dekker John 1:30 A^{M} December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Pylesville Harford 915 Old Pylesville Road Social Security Number 8. Date of Birth
(Month, Day, Year)
Feb. 14, 1932 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F 80 Director 545-66-7288 Feb. Bassum, Holland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 🗆 Yes 2 No Pylesville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 915 Old Pylesville Road 21132 United States of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2XXNo 1 Never Married 2 Married and Mental Hygiene.
is marked other than "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clergy Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Willem Dekker Pieter Gerdina Van Eybergen permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 915 Old Pylesville Road, Pylesville, MD 21132 Nita I. Dekker - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Dilaney Valley Manorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 2, 2013 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel, and Cremation Services 8800 Harford Roed, Parkville, Maryland 23a. Part 1. Ent with disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Or iii) ury that initiated events Due to (or as a consequence of): Exami and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after clearh Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown as been signed by the 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed death? this certificate 1 ☐ Yes 2 ☐ No 2 N ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 MResidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pendina within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🔐 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 12/28/2013 29c. License number R 12093 8 and title of certifie completed cause of death (Item 23a) (Type, Print) Parkville MD 21234 Watham Woods Rd

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Floy Diegel 3:45 P.M 2012 Medical December 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
January 16, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Days Hours 217-26-0849 Director 1 M 28 F 83 Maryland Usual Residence of Deceder 1929 ir then "netural", or items 23a or 28e-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Reisterstown 1 - Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g_Citizen of What Country? United States Funeral 11 Trighton Court 21136 of America 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify. 3 ☑Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene, importent: if item 27 is marked other then 'eny injury or other treumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Manicurist Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John O'Brien Irene Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Karl Scott Diegel/son 11 Trighton Court Reisterstown, Maryland 21136 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel 20a. Method of Disposition 20c. Location - City or Town, State January 3, 1 ☐ Burial ② Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2013 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir To the Hoepitel or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Then 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS CRNP 2300 DULANEY VALLEY TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
JAN 0 3 2013 32. Registrar Signatur State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Barbara I. Dombek December /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 01/28/1944 5. Social Security Number Funeral Months Days Hours Min 1 □ M 2 🕱 F Director 062-36-9111 68 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar runt by notified at Director Maryland Germantown Montgomery 10e. Street and Number 10f. Zip Code 18105 Coachmans Road 20874 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify ρ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Rinzler Sadie Steinhaus Injury or other traumatic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a 18105 Coachmans Road, Germantown, Maryland 20874 Bruce Dombek - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Garden of Remembrance; 01/02/2013 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part . Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical

Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

snock, or heart failure. List only	one cause on each line.			U.	Onget and Death	
Immediate Cause (Final disease or condition resulting in death)	1/4	Onset and Death				
Tooding in doding	Due to (6r as a consequence of):					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a consequence of):					
that initiated events resulting in death) Last	c					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		etopic pregnancy her <i>(specify)</i>		23d. Date of deliv Month	ery Day Year	
Part II. Other significent conditions of	ontributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?	
			1 ☐ Yes	2 ☐ No 3 ☐ Prol	bably 4 Onknown	
			24a. Was an autopsy performed 1 □ Yes 2 🗗	? death?	opsy findings available impletion of cause of	
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	6 ☐ Other (Specia	fy)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Work? M 1 □ Yes 2 □ No	28d. Describe how ir	njury occurred		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	and Number or Rura ate)	al Route Number,	
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of my knowledge, death or niner: On the basis of examination and/or inves and manner stated.	curred at the time, date and place, ligation, in my opinion, death occurr	and due to the caus- red at the time, date	e(s) and manner as and place, and due to	stated. o the cause(s)	
29b. Signature and title of certifier	6.4.5	29c. License number		Date signed (Month,	Day, Year)	
Corders &	VID	00064624 12-30-2012				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

42522

3. Time of Death

Montgomery

u.s.A.

14. Race - American Indian,

Federal Government

Birthplace (State or Foreign Country)

New York

White

10d. Inside City Limits

1 ☐ Yes 2 🕅 No

8:30 am

Day 30,

Year

2012

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

Rockville, MD 20850

Clarksburg. Maryland

Registrar DHMH 17 Rev 1/2001

State

SANDEEP

31. Date filed (Month, Day, Year)

Veirs

Save

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9701

32. Registrar's Signature

SHARMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:50 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Director 214-40-4054 1 □ M 2 🗓 F 97 Yrs. 02/06/1915 MD Usual Residence of Deceder 28a-f show 10a. State 10b. County or then "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No BALTIMORE MD BALTIMORE ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6533 GARDENWICK ROAD 21209 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. end Mental Hygiene, is marked other then "natural", or 1 Never Married 2 Married <u>გ</u> If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify. Specify: WHITE Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mental F မ ABRAHAM HYATT **ESTHER** 1 and 2 should be Health end Meritem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN GINSBERG / DAUGHTER 6533 GARDENWICK ROAD, BALTIMORE, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State . Pege 1 permit. Pege 1 a
Department of H
Importent: If Ite
any Injury or ot Cemetery, crematory or other place)
OHEB SHALOM
MEMORIAL PARK 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/02/2013 REISTERSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ henose RO disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death signed by the an Id be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate 1 Yes 2 D No 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence nospice မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOB

State Registrar

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42524 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 045° 47AM DEC 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** toward Howard MINT Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number (10) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Director 1 M 2 MF lune f and 2 should be filed within 72 nous a.... If Health and Mental Hygiene. If Health and Mental Hygiene. I item 27 is marked other than "natural", or Items 23a or 28a-f show I item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 □ No umbia toward 10e, Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 5368 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Never Married 2 ☑ Married ⋧ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: f Yes, Give Year or Dates Specify: Hai trank 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State venation Hansver 4 Donation 5 Other (Specify) 21. Signature of Fun Service Licensee Home MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician MONTH Due to blas a consequence of): Medical 3 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying tus tasis We. Examine attending physiclan and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physicien: The law requires that the death certificate be executed by hours after death.
Puneral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death signed by the at I be detached fo 1 Yes 2 No g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physicien: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sis completely filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed' 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending 1 🔲 Yes 2 🗌 No 2 Accident Investigation 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) 2012 son who completed cause of death (Item 23a) (Type, Print) 30. Name and address

State Registrar 31. Date filed (Month, Day, Year)

()

2. Registrar's Signature

Columbia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year 1928 2 Medical 2017 4a. Facility Name (if not illistitution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltmir Mar and v 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Sex 8. Date of Birth **Funeral** May 18, 1927 Months Hours Director -20-3859 85 Mar^Collaind 1 M 2 XX 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinations to confind at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🖼 No Carroll County Westminster Maryland Oe. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 21157 United States 505 High Acre Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Manital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 MNo
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Vividowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Acme Markets Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Grover C. Lyons Daisy Smith permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4751 Millers Station Road, Hampstead, Maryland 21074 Robert Elliott / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 The Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet. Cem January 2, 2013 Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road. Baltimore.Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician henorha Brainstein disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 🔲 Ectopic pregnancy 5 Other (specify) Month Day 1 Yes 2 9 à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24 hours after death. e Funeral Director: After this certificate has been signited in by the funeral director, page 2 should h No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 200 1 Ves 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 D res 2 D No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License numbe

State Registrar 30. Name and address of pe

31. Date filed (Month, Day, Year)

Baltmon MI)

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 4 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 06:35 AMM 12 30 2012 Margaret Mae Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Air If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth Funeral (Month, Day, Year) Months Davs **Director** 213-52-9583 1 ☐ M 2 🂢 F 02/19/1949 Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 1 Yes 2 No MD Harford Joppa 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21085 708 Ferguson Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Styrofoam Industry Machine Operator 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Sadler Charles Westlock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Ferguson Road - Joppa, Maryland William F. Fisher (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 01/02/2013 | Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 11750 Belair Road - Kingsville, Maryland Cothon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executa within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) g Unknown Fisher; margaret Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 € No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1- Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper chesapeake, Drive Bel Air MD 21014 Parsa Venkata 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JAN 0 3 2013

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examin	er	Bel Air Healthand Rehabilitation Center		Hartord
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs	8. Date of Birth 9. Birthplace (State or Foreign
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	or 28 or 28 e noti	اقّ	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
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Maryland 21215-0036	ygien ygien her th	Be C	12	Substitute Teacher	Board of Education
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fund Service Licensee	22. Name and Address of Facility E	. F. Lassahn Funeral Home, P.A.
	<u></u>		fait ship		- Kingsville, Maryland 21087
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	n 24 h	Medical	(Check 2 Medical Examiner: On the basis of examination and/o	or investigation, in my opinion, death occurred wledge, death occurred at the time, date and	d at the time, date and place, and due to the cause(s) and manner stated. place, and due to the cause(s) and manner as stated.
	To the To the Complex		29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	10		& Swale M. D.		12/31/12
	Q		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHAIL RX #101 -	TI NIR MN DIEIT
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death
3: 00 PM 2. Date of Death Physician/ Ulysses Fee December Day 3 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Loch Raven Community Living Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/01/1919 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 246-16-6743 Director 1 🔀 M 2 🗆 F 93 Yrs. S. Carolina : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director MD N/A Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3921 Mortimer Ave. 21215 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medica 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1X Yes 2 ☐ No Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Black 3 ☑ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6 th College (1-4 or 5+) Owner-Shell Service Stat! Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Leroy Fee Mary Kirkland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette McIntyre 101 Matador Ct. Ft. Worth, TX 76108 (Neice) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Evergreen Cemetery 1 X Burial 2 Cremation 3 Removal from State 1/3/13 Winston Salem, NC 4 Doylation 5 Other (Specify) 21. Signatur of Funeral Service Lines ²² Joseph Falbrown Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Prostate Interval Between Immediate Cause (Final disease or condition Onset and Death 251 Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of ours after death. eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transif or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DISERSE Kidney 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 2 M No 1 Yes 25. Was case referred to/medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) on who completed cause of death (frem 23a) (Type, Print) 5-20 VA2 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ aron 2012 Decembe Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5Am TIMO 8. Date of Birth Month, Day, Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. Funeral 88 Hours 1 M 2 F Months Days Min. (PAROLINA Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** iral", or items 23a or 28a-f s Examiner must be notified 1 🗓 Yes 2 🗌 No MOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 650 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify: "natural", Completed 3 ☐ Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Kind of Busines (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Las 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is y or other tra altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License JONES 23a. Fart 1. Enter the disease, or complication: that caused the death. Do not enter the mode of dying, such as cardiac or regiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death nysician/ disease or condition resulting in death) Medical Due to (or as a conse lu- of) **Examiner** Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Seon burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
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1 Yes 2 No Pregnant at time of death Month Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been sig ; page 2 should b Completed 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn Director: After this certificate 2 🕅 No 1 Tes Yes the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Wind Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death. Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 2013 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month FULLARD OUMAN 5:38 DECEMBER Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death RANDALLSTOWN NORTHWEST BALTIMORE HOSPINAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 73 1 M 2 X F 2/26/1939 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Woodlawn Baltimore 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21207 6828 Richardson Road Page 1 end 2 should be filed within 72 hours after death v ment of Health end Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 27 is marked other than "natural", or Items traumatic event, the Medical Examiner man Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Specify: Black 3 ₩ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Entrepreneur/Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental F is marked o 9 Lillie Frierson <u>Alvin Fullard</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6828 Richardson Road Venise Steeple/daughter Woodlawn, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If its any Injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 1/5/2013 Baltimore, Mem. Park 21. Signature of Theral Service License 22. Name and Address of Facility 4300 Wabash Avenue 21215 March FH West Baltimore, MD Part 1. Enter the disease, or complete his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Exam resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 1 Yes 2 No 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 W No 1 Yes 2 Wo Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဝ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 00060293 DECEMBER 30 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMED. 5401 OLD COURT RD MURTURA M.D. RANDALLSTOWN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

JAN 0 3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #2, per phy, g935 1-14-13 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Da 27 Month Physician/ lliam Mai 1010ecembo 2010 Medical 4a. Facility Name (if nqt institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore NIA enwoo 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 **Funeral** 6. Sex Months Days Hours Min. Month, Day, Year) 1 M 2 F **Director** Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland must be notified at **Funeral Director** 1 Xes 2 No Hora 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Aue 23a 2120 Kenwood or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Yes 2 No If Yes, Give Year or Dates. ρ 1 Never Married 2 Married e 1 and 2 should be filed within 72 hours after cof Health and Mental Hygiene.
If item 27 is marked other than "natural", or nother traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: HIQCK 3 ₩idowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) estinghous Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iliam Jari enwood H More 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, 1 Surial 2 Cremation 3 Removal from State Mills MD 2013 4 Donation 5 Other (Specify) Signature of Funeral Serv ce Lic 22. Name and Address of Facility Hora Keral nms M Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequen To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No death. Investigation 6 Could not be Accident filled in by the within 24 hours after deat **To the Funeral Director**: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie completely Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 Signature 29d. Date signed (Month, Day, Year) and title D007128 Of person who completed cause of death (Item 23a) (Type, Print) (By St. # 4105, Balthmore, MD

Registrar DHMH 17 Rev 06-2011

State

Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death reston **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 1 M 2 MF 1960 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho treumatic event, the Medical Exemiter must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Hmore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other treumatic event, the Medical Examiner many injury or other treumatic event, the Medical Examiner many. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NQT use retired) /Secondary (0-12) College (1-4 or 5+) rivate Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Brown tavia. ewis Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) lewood t. Edgewood 20b. Place of Disposition (Name of cemetery, crematory or other Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cansdown, 21. Signature of Funeral Service Licensee March 22. Name and Address of Facility 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dullo (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the deeth certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the ettending physicien end mopletely filled in by the funeral director, page 2 should be deteched for use as the burla. Transit iabetes mellitus Due to (or as a consequence of): resulting in death) Last Physician/Medical chronic obstructive Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Pregnant at time of death 1 Yes 2 S 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by obesity 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown hypercholestendemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 🗌 Yes 2 110 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01-02-2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

32. Registraris Signature

4340 Park Haights Ame Balton MD 21215

Hichardson

31. Date filed (Month, Day, Year)

JAN 0 3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Month Rem Physician/ 5:36 PM Laura Emily Gunby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Baltimore Good Samaritan Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 214-32-6390 Director 1 M 2 X F 95 Nov. 27, 1917 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location Director Parkville 1 Yes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21234 United States 1211 Deanwood Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked out any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Lewis Gunby Jessie Alice Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Hueper / 1211 Deanwood Road, Parkville, Maryland 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/31/2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sate has been signed by the attending physician end page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗀 No မြ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie se of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First. Middle, Last) 2. Date of Death Month 7 Physician/ :15 AM 2 CALVIN GRANESE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE MANOR CARE OF DULANEY TOWSON If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** (Month, Day, Year) Hours Min. 212-24-4828 **Director** 1 XM 2 - F 8/12/1937 MD 75 Usual Residence of Decedent 28a-f show 10d Inside City Limits 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 XYes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 LINEAGE COURT 21202 USA hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian . Was Decedent Ever in U.S 11. Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1-Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates UNK 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) l Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12 STORE OWNER BEVERAGE is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev JOSEPH CONSTANTINE GRANESE ELIZABETH DINA HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) DEBORAH GRANESE - DAUGHTER 5 LINEAGE CT. BALTIMORE. MD 21202 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State MT. CARMEL 12/28/12 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SKARDA FUNERAL HOME mo/120 2829 HUDSON ST BALTIMORE. 21224 Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Kanoma Physician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of): Cancer state Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) signed by the at P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Division of Vital Records, Completed plnous 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has page 2 autopsy Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗎 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: the Hospital or Attending on.
s after deam.
ral Director: After 5 - Pending Natural Accident Suicid Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 ☐ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CYTUS ASadi, 1012 Falls Croft W 82. Registrar's Signature

H0054424

Way Luthervally MD 21093

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 25,27, per me, g935 1-29-13 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 5:26 AM 2012 rave. December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner more If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 244-38-5660 Director 1 🗆 M 2 🔀 F 91 192 Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Md. 1 es 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3116 ht wodo 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify. 3 Widowed 4 N Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ssistan to s Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ John CIL j Son 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reidsville MILCR Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Burial 2 Cremation 3 Removal from State Ruffin , N.C. 27326 Ja 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License lapst. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CHETTER ATION APPROVED BY MEDICAL EXP Medical Due to (or as a consequence of): Examiner Kecent th Harden Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) signed by the attending physician and id be detached for use as the burial-transit Delindraha Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funerel Director. After this certificate has been signompletely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes -2 1 မ 1 Inpatient 2 ER/Outpatient 3 I DOA Date of injury (Month, Day, Year) 28c. Injury at work?
1 🗌 Yes 2 🕱 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending subject tell Investigation 23/2012 5:00 PM 2 X Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)
3116 Brightwood Avenue, Gwynn Oak, MD determined home Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Projection: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 01/12 D7 37 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 MP 21234 Waltha 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

CAVES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42536 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 11:18 DECEMBER 2012 Sanders Grabil1 Aileen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAINT JOSEPH MEDICAL CENTER TOW SON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Director 525-24-6094 1 □ M 2 🛛 F 94 Oct 23, 1918 Texas Usual Residence of Dece 28e-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location filed within 72 hours efter death with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Baltimore Timonium 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number Funeral 23a 21093 USA 11 Salthill Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☑ Widowed 4 ☐ Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home n/a <u>Homemaker</u> Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o GEARTLY, PTLEEN မ Sanders Virginia Theodosia E1i Beaty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 12240 Roundwood Rd., #805, Timonium, MD 21093 Karen Grabill Donica/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 s
Department of H
Important: If ite
eny injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans Cem. Owings Mills, Maryland 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 21. Si un un uneral Service Licens Bryan W. Clary 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Onset and Death MINUTES Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day 4 Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CARDIOMYOPATHY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 🗹 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 K ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t in 24 hours after death.
the Funeral Director: After 1 🗵 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou To the Funel completely fi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 05 LER ORIVE TOWSON, MD J. BEAUVOIS

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number

062551

29d. Date signed (Month, Day, Year) 12.30.12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December Physician/ 11:20pm Michael Green Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 5308 Augusta Street Bethesda Montaomeru Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 107-36-7662 Director 1 X M 2 □ F 66 11/02/1946 New York th end Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medicel Examiner must be notified at</u> 10d. Inside City Limits 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5308 Augusta Street 20816 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☑ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates. Vietnam 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Law Lawyer 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Green Jean Pauls Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health eitem 27 I 5308 Augusta Street, Bethesda, Maryland 20816 Marilyn Green - Spouse or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Importent: If ite
any Injury or oth 1 Burial 2 Cremation 3 Removal from State Norbeck Memorial Park 12/30/2012 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa@re of Funeral Service, Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause of the entertion of the cause of the entertion Approximate Interval Between Onset and Death MONTHS LIOBLASTOMA MULTIFORME Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use es the burlal-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy performed?

1 Yes 2 No. 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Ren. No. 2012 42538 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Year Month GRITSCH **Physician** ERIC 14:10 PM DECEMBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE CITY Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□F Days Hours 102-30-6745 81 04/19/1931 AUSTRIA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ms 23a or 28a-f show must be notified at 1 X Yes 2 No Director N/A MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 2623 EASTERN AVENUE U.S.A.

14. Race - American Indian,
Black, White, etc. 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status or other traumatic event, the Medical Examiner filed within 72 hours after 1 Never Married 2 Married ö 1 ☐ Yes 2X No Specify: þ WHITE 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5 + THEOLOGIAN LUTHERAN CHURCH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First. Middle, Last) . Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 is marked oth Be GRITSCH MATTHIAS MATTES IRENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any Injury or other trau BONNIE BROBST/ WIFE 2623 EASTERN AVENUE, BALTIMORE, MD_ 21224 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State BAYVIEW CREMATORY 12/31/12 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
LILLY & ZEILER INC
1901 EASTERN AVENU 21. Signature of Funeral Service Licensee ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21231 Approximate Interval Between Onset and Death Immediate Cause (Final DAYS **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** CHOLECYSTITIS NECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Live birth 2 Fetal death Month Year Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Tyes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \(\sum \) Nursing Home \(5 \sup \) Residence \(6 \sup \) Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation Injury or Attending 1 X Natural s after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Maryland 21215-0036

Baltimore,

Box 68760

of Vital

Division

State Registrar 29b. Signature and title of certifier

3.

GEROLD DO

22. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

DECEMBER 29, 2012

DHMH 17 Rev 1/2001

29c. License number

4-31298

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 Gaither Robert В. 26 2230 M Dec. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PG Clinton Southern MD Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 577-54-9537 05-26-1941 worth Carolina Director 1 X M 2 □ F 71 Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other then "neturel", or iteme 23a or 28a-f show emy injury or other treumetic event, the Medical Examinet must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Forestville PG MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20747 Funeral 1311 Shady Glen Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Armed Force Black, White, etc. Specify: Black 2 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private **Energy Coordinator** å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Addie McCoy ပ္ Hines 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1311 Shady Glen Dr. Forestville, MD 20747 19a. Informant's Name/Relationship (Type, Print) Mary Gaither/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 01-04-2013 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FR 21. Signature of Funeral Service Licens of our 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ IEUM disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner P515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physicien: The law requires that the deeth certificate be executed attending physiclen and for use es the buriel-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) ed by the a g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I certificete has been signed l lirector, pege 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medica 8 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 42mon 39

Registrar

31. Date filed (Month, Day, Year)

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42540 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / 2 Physician/ Year GRAVINA 5:15a^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Baltimore Manor Care-Ruxton

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 214-24-2154 Hours Min. (Month, Day, Year) Director 94 Yrs. 1 □ M 2 🗓 F 4/6/1918 MD 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239-3846 5037 The Alameda 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Johns Hopkins Nursing Assistant treumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be file lith and Mental F 27 is marked o ည Ella Norris Horace Whitworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 Baltimore, MD 21239 5037 The Alameda Alice Faulcon-sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s
Department of H
Importent: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Mem. Park 1/3/2013 Arbutus, MD Arbutus Signature of Funeral Service Licensee 22. Name and Address of Facility Same 4300 Wabash Avenue March FH West Baltimore, MD 23a. Part 1. Enter the disconstructions or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition Medical resulting in death) Examiner Failure to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the human transit Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? 2 🏳 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ø Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Division 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number tohavnest learn 73575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bhouncet Bharaj 8813 Waltham Woods Rd Parkville MD-21234 32. Registrat's Signature 31. Date filed (Month, Day, Year)
JAN 0 3 2013 State

DHMH 17 Rev 06-2011

Registrar

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of Vital

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Marylar		tificate of		and iv	- Iciliai i iy	Reg. No	2012	2 42541	
	Physicia	n/	Decedent's Name (First, Middle, Last)				-		Date of De Month	ath Da	ay Year	3. Time of Death	
	Medic Examin		Joyce Garrison 4a. Facility Name (if not institution, give stre			4b. City, Town	, or Location of	of Death	12/2		County of Dea	5:45A M	
	/ 		Hospice Queen Ar 5. Social Security Number 6. Sex	ne's	ast hirthday)	Cent	revil		8. Date of Bir			Anne's	
	Funeral Director		214-46-1320 1 🗆 1	M 2 X F 6 4	Yrs.	Months Day		Min.	(Month, Da	y, Year)	C	ountry) MD	
	show det	tor	Usual Residence of Decedent 10a. State 10b. County WV Kanawha	10c. Cit	y, Town or Lo					,		10d. Inside City Limits	
	e Mary r 28a-f notifie	Direc	WV Kallawila 10e. Street and Number		Charl	eston				10.0		1 ☐ Yes 2 🂢 No	
	s 23a o	Funeral Director	289 E Hunter Roa	ad		253				10g. C	itizen of What C	ountry?	
036	1 and 2 should be filed within 72 hours after death with the Maryland if Health end Mental Hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-f show other treumetic event, the Madical Examinar must be notified at	by	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 XDivorced	. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1 ☐ Yes 2 ☒ No If Yes, Give			Nas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto R			14. Race - Am Black, Whi Specify: Wh	te, etc.	
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and	l be filed v lental Hyg rked oth	To B	17. Father's Name (First, Middle, Last) Richard H. Humme	ell			18. Moth	er's Name ice	First, Middle, Eliza	<i>Maiden</i>	Surname) h Ewin	ng	
, Maryland 21215-0036	id 2 should saith end Me n 27 is marl er treumeti		19a. Informant's Name/Relationship (Type, Marshall Alan Hu	Print) ummell Son	19b. Mailir 1617	ng Address (Stre	et and Numbe	r or Rura Ve (I Route Numbe Ocean	er, City o	r Town, State, Z Y MD 2	^(ip Code) 21842	
Baltimore,	ege 1 and nt of Heal t: If item 2		20a. Method of Disposition 1 ☐ Burial 2 【▼Cremation 3 ☐ Re	moval from State	emetery, cren	sition (Name of natory or other p			Date	l .	ocation - City o		
altın	permit. Pege 1. Depertment of I Important: If it any Injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	1 / a	22		ress of Facilit	y Sir		ty	Crem 8	rnie MD Fun Serv	
20	88 58	1	Athoms / H			· · · · · ·					Rd Ha	nover MD	
	Physician/		23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one of Immediate Cause (Final disease or condition	cause on each line.	,		ying, such as	cardiac o	r respiratory at	rest,		Approximate Interval Between Onset and Death	
لمحبر	Medical Examiner		resulting in death)	Due to (or as a conseq		1	132776					1000	
	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):								
	icate be executed physicien end is the burial-transit	fedical Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	initiated events C.									
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789 x09	To the Hospital or Attending Physician: The law requires thet the death certifics within 24 hours after death. To the Funeral Director After this certificate has been signed by the ettending p completely filled i⊨ by the funeral director, page 2 should be detached for use es	₹	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	b. If yes, outcome of pregnation 1 ☐ Live Birth 2 ☐ Fet.	aldeath 3	Ectopic pregna	ancy				23d. Date of d	elivery Day Year	
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ds, P.O	tuires the on signed uld be de	by	Part II. Other significant conditions contri	ibuting to death but not res	nt not resulting in the underlying cause given in Part I.							to the cause of death? Probably 4 Unknown	
Vital Records,	ne law red e has bee age 2 sho	Completed							24a. Was auto perfe	psy ormed?	prior to death?		
<u> </u>	olan: Ti ertificat ector, p	Be C	25. Was case referred to medical examiner?	b		26.	Place of Dea	th (Check	1 🗆 Yes only one)	2 LJB N	lol 1 L Ye	es 2 🗆 No	
<u> </u>	Physic rthis ceral dire	မ	1 ☐ Yes 2 🖾 No Hos 27. Manner of Death	spital: 1 Inpatient 2 28a. Date of injury	ER/Outpatier 28b. Time of	t 3 LI DOA	other: 4 □ Nu jury at		me 5 Resi			CENTER	
50	eath. or Afte the fun	Certificate:	1 🛪 Natural 5 □ Pending 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be	(Month, Day, Year)	injury	w	ork? ☐ Yes 2 ☐	- 1	Edd. Describe	now inju	ry occurred	Con	
DIVISION OF	tal or Att irs after d al Direct led i by		4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, offic	e			Location (Street and Number or Rural Route Number, City or Town, State)			
	e Hospi 24 hou e Funer detely fil	Medical	(Check 2 Medical Examiner	an: To the best of my know On the basis of examination Practitioner: To the best of its	n and/or invest	tigation, in my op	inion, death o	ccurred at	the time, date	and plac	e, and due to the	cause(s) and manner stated.	
	Vithin Congress		29b. Signature and title of certifier			29c. Lice	nse number			29d. Da	ate signed (Mon	th, Day, Year)	
	() m		30. Name and address of person who com	pleted cause of death (Iten	n 23a) (Type, F	12.0	63747				12/28/2	2012	
	2 4		TERROY VICENY	M 25	40 6	-Trevil	la po.	49, C	enrevi	Re	m	21617	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ELLIS HOLEMAN 10:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE MORWOT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 420.54.9511 Director 1 M 2 D F Yrs. 19 1941 AL permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23a or 28a-f show way hjury or other treumatic event, the Medical Evaniner must be notified at once. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director BALTIMORE MD 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6100RIDGEVIEW AVENUE 212010 DRA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College(1-4 or 5+) POST OFFICE POSTALTRUCK DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ FREEMAN HOLEMAN UESSIE BEARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE PELHAM, DAUGHTER 6100 RIDGEVIEW AVE BALTO, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2013 BALTIMORE, MO 5 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL 22. Name and Address of Facility
VAUGHTU C. GREENE FUNERAL SVCS
4905 YORK RD. BALTO, MO 21212 21. Signature of Funeral Service Lic Zww 8 BALTO, MO 21212 23a. Part 1. Enter the disease or combligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner vancular disease englund Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine pete hes been signed by the attending physician end page 2 should be deteched for use es the burial-trensit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

December 28 20/2 29b. Signature and little of certifier ress of person who completed cause of death (Item 23a) (Type, Print) Charles ST TONSON AAAAA J. CM 31. Date filed (Month, Day, Year) WD 6701 732. Registrar's Sig State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland /			lental Hygier	ne 2012	1,2544
			State Registrar		Certificate of	f Death	Reg.	No.	76077
	Physicia		1. Decedent's Name (First, Middle, Last)	sencer Ha	Krine).	Sr.	2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give s	reet and number)	4b. City, Town	, or Location of Death		4c. County of Death	
	Funeral	17.	5. Social Security Number 6. Sex	7. Age (In yrs. last b.	inthday) If Under 1 Yes	CLAIC, /	8. Date of Birth	9. Birthol	ace (State or Foreign
	Funeral Director		A 11 A A A A 2 1	Íм2□F 75	Months Day	s Hours Min.	(Month, Day, Yea	r) Countr	7
	ind show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location		4/000/110	10	d. Inside City Limits
	Maryla 28a-f s otified	Director	MD Baltime	re Roser	dale				1 ☐ Yes 2 No
	ith the 23a or st be n		10e. Street and Number	A.12 A + 11	10f. Zip Code	2/237	10g.	Citizen of What Count	ry?
	eath w	Funeral	13.15 Chesa Co	12. Was Decedent Ever in U.S.		f Hispanic Origin? (Speuban, Mexican, Puerto	cify Yes or No-	14. Race - America	
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21215-0036	hours natura dical E	Completed by	15. Decedent's Edu (Specify only highest grad		Sa. Decedent's Usual Occ	cupation ne during most of work	16b	. Kind of Business/Ind	ustry
121	within 72 giene. ner than '	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. DO NOT use retire	More than the state of the stat	" R	Lath. Ste	el
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Maryland	uld be fill I Mental narked o	To	James W. Ha			Kmil	/ West		
Ma	12 should lith and M 27 is mai	- 3	19a. Informant's Name/Relationship (Typ) Debova Haskins	- Dancister 1	9b. Mailing Address (Stre		1 - 0	or Town, State, Zip Ci	0de) 1, 29.2.23
ore,	e 1 and of Heal If item 3		20a. Method of Disposition 1 Burial 2 Cremation 3 F		of Disposition (Name of stery, crematory or other p			. Location - City or Tov	vn, State
Baltimore,	permit. Page 1 s Department of H Important: If ite any injury or ot once.		4 Donation 5 Other (Specify)	Kina		PK. 12-15	2012 Ka	ndallstown	, MD
Ba	Depar Impol any ir	Į.	21. Signature of Funerat Service License	K. Jmed	22. Name and Add	Jorth Ave	Baltim	-EUST DHE, MD 2	12.02
Н			23a. Part 1. Enter the disease, or complishock, or heart failure. List only one		o not enter the mode of d	lying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Medical	e P	Immediate Cause (Final disease or condition resulting in death)	Farhre to	Thribe	in Adul	thood		Onset and Death
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687	ertifica ding ph se as t	/Me	IF FEMALE:	3c. If yes, outcome of pregnancy				23d. Date of delive	
Box 6876	death c e atten ed for u	siciar	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal dead 4 Pregnant at time of death 9 Unknown					Day Year
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Division of Vital Records,	aw req as bee 2 sho	nplet					24a. Was an autopsy	prior to con	sy findings available npletion of cause of
Re	'sician: The law r certificate has t director, page 2 s		25. Was case referred to medical			Discould Death (Observed)	performed	? death? 1 Yes	2 🗹 No
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J O	ing Ph		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	injury W	njury at	28d. Describe how in	njury occurred	
sior	Attendi r death. ector: A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home,		Yes 2 No		and Number or Rural	Route Number,
Ω	To the Hospital or Attending Physician: "Thin 24 hours after death as a feet death. To the Funeral Director: After this certificacompletely filled in by the funeral director,			building, etc. (Specify)			City or Town, St		
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check 2 Medical Examin	cian: To the best of my knowledger: On the basis of examination and Practitioner: To the best of my kn	d/or investigation, in my or	oinion, death occurred a	t the time, date and pla	ace, and due to the cau	se(s) and manner stated.
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0			30. Name and address of person who co	2 2	DizAzl Dr.	Suffe 6	Conthrem	MD, 2	1090
	Stat Registra		31. Date filed (Month, Day, Year) JAN 0 3 2013	32. Registrar's Signature	wed				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 105 otting 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Director 1 🗶 M 2 🗆 F 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 💥 No rana 1 f. Zip Code 10g. Citizen of What Country? Funeral 103 'natural", or items Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

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1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mitte MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOGLYCEMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, DISORDER 1 Yes 2 No 3 Probably 4 Lunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funerall Director Afte completely filler in by the fun 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4408, Freastine lave Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the bast of my kn, which go death occurred at the time date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43378 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kosi. Pikams 31. Date filed (Month, Day, Year)

JAN 0 3 2013 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

•	Please Type or Pri	i nt in Black Indelible In EM#3perPHYS,G935,I laryland / Department of	k. Ensure All Copie:	s Are Legible.
	1 - State Of IVI	Certificate of	Donath	Reg. No. 2012 42546
Physician/	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	ath 3. Time of Death
Medical Examiner	Christopher Hartman 4a. Facility Name (if not institution, give street and number)	4b. City. Town.	Decem or Location of Death	ber 27 2012 /:40 P**
Laminer	GREATER BALTIMORE MEDI		SON	BALTIMORE
Funeral Director	5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birthday) If Under 1 Year Months Days	Hours Min. (Month, Da	y, Year) Country)
1	Usual Residence of Decedent	67 Yrs.	Jan. 23	1, 1945 New York
aryland aryland bet she at she	10a. State	10c. City, Town or Location	eysville	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
The Me The Me	10e. Street and Number	10f. Zip Code	ysville	10g. Citizen of What Country?
LAP heL Jeath with the Meryland items 23a or 28e-1 sho err set Les notifies at Funeral Director	4B Queensbridge Court		21030	United States
هَ يَوْ وَلَا	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 X Divorced 12. Was Decedent Armed Forces? 1 Yes 2 Yes Give Year or Dates.	Ever in U.S. 13. Was Decedent of If Yes, specify Cut 1 \(\sum \) Yes 2 \(\sum \) N	Hispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White
21215-003 within 72 hours et lene. r then "netural" the Medical Ext	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occu (Give kind of work done	during most of working	16b. Kind of Business/Industry
Within giene.	Elementary/Secondary (0-12) College (1-4 or 4	5+) life. DO NOT use retired Public Relat	•	City of Baltimore
and; and; be filed v antal Hyg ked othe c event,	17. Father's Name (First, Middle, Last) Walter C. Hartman		18. Mother's Name (First, Middle, Anne M. Schne	Maiden Surname) eider
aryla biolid bio	19a. Informant's Name/Relationship (Type, Print)	19b Mailing Address (Stree	and Number or Rural Route Number	
TY , Mg; , Mg2 sh and 2 sh and	Mariellen Etter / Sister			de, New Jersey 08075
Baltimore, Separation of He moporant: If item may injury or other mice.	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
altin Partin Par	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ALYSON	Metro Crematory J	nc. 12/28/2012 ess of Facility cremation	Baltimore, Maryland Society of Maryland Inc
T W ESEE	Afailitees			more, Maryland 21228
Physician/ Medical Examiner Examiner Examiner	Sequentially list conditions.	ed the death. Do not enter the mode of dy le. onany Embolism a consequence of): Venous Thrombos a consequence of		rest, Approximate Interval Between Onset and Death (unknown)
Division of Vital Records, P.O. Box 68760 To the Hospitei or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Medical Certificate: To Be Completed by Physician/Medical Examin	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	2 ☐ Fetal death 3 ☐ Ectopic pregnal at time of death 5 ☐ Other (specify)	ncy	23d. Date of delivery Month Day Year
at the d by th detached	9 Unknown Part II. Other significant conditions contributing to death to		iven in Part I. 23e Did t	obacco use contribute to the cause of death?
IS, Puires the n signe and be of by	Congestive Heart Failure	٤		Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
/ital Records, rsician: The lew require s certificate has been si director, page 2 should I	Atrial Fibrillation		24a. Was auto perfc 1 ☐ Yes	
ital	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	lo _t	Place of Death (Check only one)	
Division of Vital Rec To the Hospitei or Attending Physician: The le within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page: Medical Certificate: To Be Com	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ury 28b. Time of 28c. Inju yo injury wo	ry at 28d. Describe h	dence 6 Other (Specify) now injury occurred
Divisi Divisi Ditei or Attu urs after de urel Directo Illed in by t	building, et	jury - At home, farm, street, factory, office tc. (Specify)	City or Tov	
he Hospite in 24 hours he Funerel pletely filled	29a. Certifier (Check 2 Medical Examiner: On the basis of e only one) 3 Certifying Nurse Practitioner: To the	examination and/or investigation, in my opin	ion, death occurred at the time, date a	and place, and due to the cause(s) and manner stated.
To th within	29b. Signature and title of certifier Gha G Gunawalt Ma	29c. Licen	se number .0 2 4 8	29d. Date signed (Month, Day, Year)
	30. Name and address of person who completed cause of o	death (Item 23a) (Type, Print)		December 27, 2012 D 21284
State	31. Date filed (Month, Day, Year) 32. Registr	161 North Charks Str 18 Signature	eet partimore, M	V 224
Registrar	JAN 0 3 2013 Senera > B	1. parlet		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 42547

			ertificate of Death	Reg. No.	
Physici		1. Decedeni's Name (First, Middle,Last) Winston Maurice Henson		Date of Death Month Day Year December 24, 2012	3. Time of Death 0516 hrs
		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of De	
Funeral		Social Security Number 6. Sex 7. Age (In yrs. I	last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth(MM/DD/YYYY) 9. I	
Director		218-62-9463 _{1XM 2} F	58 Yrs. Months Days Hours Min.		eign Country) MD
v any			r, Town or Location		10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ctor	MD N/A Ba I	ltimore 10f. Zip Code	10g. Citizen of What Co	1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.	Director	6610 Eberle Dr. Apt. 104	21215	U.S.A.	
eath with items 2	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No	J.S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I		erican Indian, Black,
s after de ral", nr	by F.	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		lack
5 72 hour n "natu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of working life, DO NOT use retire	ed)	
5-0036 iled within 7 Hygiene. In the Medica	Completed	12th 17. Father's Name (First, Middle, Last)	Welder 18.Mother's Name	(First, Middle, Maiden Surname)	ction Co.
21215-0036 uld be filed within 72 hours af Mental Hygiene. marked ather than "natural" c event, the Medical Examin	Be	Kenneth Bonner	Marion	Levrone	
	2	19a. Informant's Name/Relationship (Type, Print) Samuel Wilson (Brother)	19b. Mailing Address (Street and Number or Ro 6610 Eberle Dr. Ba		
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury ar other traumat		1 X Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place) 1/4	Date 20c. Location - City 2/2013 Landsdo	
Baltimore, permit. Pages 1 ar Department of Hes Important: If ite Injury ar other tr		4 Donation 5 Other Specify: 1. Signs the of Funeral Service Licen			
	(25.1. Put I. Enter the disease, or complications that caused the death	22 Sept Adres In Facility Own 2140 N. Fulton A	Ave. Baltimore	, MD 21217 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line.	Ethanol Intoxication	respiratory arrest, shock, or freat	Between Onset and Death
ZXAIIIIIEI	0	or condition resulting in death) Due to (or as a consequence or			
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	of):		
asi e 08	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.	νή:		
60, ate be execu hysician and e burial - tra	Medical		28a-f.per me.g935 1-14-1 FH,G935,1/3/2013,WS	3 sm	
38760, rtificate be ing physici as the buri		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of preg		23d. Date of deliv-	ery Day Year
Box 687(e death certificathe attending pled for use as the	Physician/	4 Pregnant at time of de 1 Yes 2 No 9 Unknown 9 Unknown	eath 5 Other (Specify)		
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	by P	Part II. Other significant conditions contributing to death but not re	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute	
ords, w requires to been significantly be	leted	11		24a. Was an 24b. Were	autopsy findings available o completion of cause of
	Completed			performed? death* 1 ✓ Yes 2 No 1 ✓	? '
ion of Vital ttending Physician: teath. tor: After this certifi the funeral director,	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	26.Place of Death (Check or Ber/Outpatient 3 DOA Other, Nursing	nly one) 3 Home 5 Residence 6 🗸 Ott	ner: Scene
ding Ph	-1	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)		28d. Describe how injury occurred subject took met	hadone and
VISION or Attend ther death. birector: in by the	Certification:	2 X Accident Investigation Id 12-24-12		subject took met Alcohol 28f. Location (Street and Number or I	Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined (Specify) Hor		or Town, State) 6610 Ebe Baltimore, MD.	
Fo the H vithin 24 Fo the F	Medical	(Check only one) 2 Medical Examiner: On the basis of examination at and manner stated.	dge, death occurred at the time, date and place, and of and/or investigation, in my opinion, death occurred at		
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (A December 25,	
- #		30. Name and address of person who completed cause of death (Item	n 23a)		
	ate	Ana Rubio M.D., Ph. D. Assistant Medical Exar 31. David (Mant) David (ear) 32. Registrar's 2009		nore, MD 21223	
Ponie		JAN U O CUTO LENGUA P. 19 1996	R Towns		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42548 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Anthony G. Hicks 4:06 PM Medical 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin 5. Social Security Number Square HOSPITO ROSE dale
If Under 1 Year | If Under 24 Hrs. timore 8. Date of Birth (Month, Day, Year) 11/08/1957 **Funeral** Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 213-70-1097 Director 55 Yrs. 1 🛣M 2 🗆 F MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 √Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Anthon Funera 2910 Auchentoroly Terr. 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Mamied ۾ 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Papartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event". (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 t h College (1-4 or 5+) Self-Employed House Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anderson Hicks Bertina Elliott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Hicks (Brother) 2910 Auchentoroly Terr. Balto., MD 21217 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place On-Site Crematory Baltimore, 21. Signature of Fun al Service Licens 22. Yoseph H. Brown, Jr. Funeral Home PA 2140 N. Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pmysiciani disease or condition resulting in death) Brain Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit · Stage 1409 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been signe, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes PNo the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 ☑ No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, within 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number Resococ 201 30. Name and address of person who completed eause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

S

Baltimore,

9000 Franklin Square Drive

32. Registrar Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		State o	f Maryla		artment o rtificate o				giene Reg. No?	012	42549
	Physicia		1. Decedent's Name (First, Middle, La	st)						2. Date of Dea Dec-15-2	ath	Year	3. Time of Death 0130 / M
	Medic Examin	al -	Anna Mae Hy		e street and nun	nber)		4b. City, Tow	n, or Locatio	n of Death	Dec-13-	_	ounty of Death	
	Examin	GI	Northwest						ltimore				Baltimore	
	Funeral Director		5. Social Security Num 214-26-8483	nber 6. S	Sex I □ M 2 1x1x F		s. last birthday	If Under 1 Your Months Da	ear If Und ays Hours	er 24 Hrs. Min.	8. Date of Birt (Month, Da	y, Year)		inplace (State or Foreign Intry)
			Usual Residence of	Decedent		83					Nov 9, 1	929		MD
	ryland -f sho led at	Director	T/20-	Ob. County Anne Ar	lobou		City, Town or L Clen Burr							10d. Inside City Limits 1 ☐ Yes 2 ▼No
	he Ma or 28a e notif	Dire	MD 10e. Street and Numb		unde i	`		10f. Zip Co	de		-	10g. Citize	n of What Co	untry?
	s 23a	Funeral	95 Mary Lan	e, Apt 20					1061				USA	
936	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed For 1 Tyes If Yes, Giv Year or D	orces? No ve	U.S. 13	Was Decedent If Yes, specify (Cuban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		. Race - Amer Black, White becify: Whi	e, etc.
2-0	2 hours	plete		15. Decedent's fy only highest g)	(Giv	edent's Usual O	one during m	ost of work	ing	16b. Kind	of Business/l	Industry
121	ithin 7; ene. • than the Me	Completed	Elementary/Secon		College (1			DO NOT use ret lomemaker	ired)			O	wn Home	
2 ام	filed w al Hygi I other vent, 1	a B	17. Father's Name (Fil	rst, Middle, Last,							ne (First, Middle,		mame)	
ylaı	Jid be I Menta narkec	잍	Thomas Rumbley Anna Odellia McGee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State								State Zin	Coda		
Baltimore, Maryland 21215-0036	12 shou alth and 27 Is n r traum		19a. Informant's Nam Elwood Bowm		Type, Print) Son		19b. Ma	iling Address (St 2 Mulberry	reet and Nur Ave, F	nber or Run Pasaden	a, MD 211	er, City or 10	wn, State, Zip	(Code)
ore,	e 1 and t of Heg If item or othe		20a. Method of Dispo		Removal fron		b. Place of Dis cemetery, cr	oosition (Name o	of r place)		Date		ation - City or	
ţ	it. Pag irtment irtant: injury o		4 Donation	5 Other (Spec	cify)			en Cemeter 22. Name and A			19, 2012	Glen	Burnie,	MD
Ba	perm Depa Impo any i	l d	- June	ry Kink	M01148			Fink Fu	neral He	ome, P.	A. en Burnie.	MD 21	061	
		Г	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between											
-	Physician/	N	Immediate Cause (F disease or condition resulting in death)	inal	_ a			CUA	1					Onset and Death
	Medical Examiner		resulting in death		Due to	(or as a cons	sequence of):							
	÷	iner	Sequentially list con- if any, leading to imr	ditions, nediate	b. Due to	(or as a cons	sequence of):							
	cate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or in that initiated events resulting in death) La	njury	c. Due to	(or as a cons	sequence of):							
0	e be ex /sician e buria	ical			■ d									
3876	rtificate ing phy e as th	Med	IF FEMALE:		23c. If yes, or	taama of are								F
Box 68760	Attending Physician: The law requires that the death certificate be executed or death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 € 9 ☐ Unknown	onths?	1 🗆 Live	e Birth 2 🗀 gnant at time	Fetal death	Ectopic pre				23	3d. Date of de Month	Day Year
P.O.	that th	by P	Part II. Other signific	cant conditions	contributing to	death but no	t resulting in th	e underlying cau	ise given in F	Part I.				o the cause of death?
rds,	equires een sig nould b	peted									1 L 24a, Was			Probably 4 Punknown utopsy findings available
eco	e law r e has b ige 2 sl	Completed by						48.8			auto	opsy formed?	prior to death?	completion of cause of
a R	i cian: The certificate rector, pag	Be	25. Was case referre	d to medical					26. Place of	Death (Che		2 ♣ No	ı ı te	12 hatract
Z.	Physici this ce al direc	은	examiner? 1 Yes 2	No				tient 3 DOA		☐ Nursing H	lome 5 ☐ Res			city) hospiac
n of	ding F th. After t funer	cate	27. Manner of Death 1 Active 2 Accident	5 Pending	(Mo	e of injury onth, Day, Yea	28b. Time injur		. Injury at work? 1 Yes	2 🗆 No	28d. Describe	now injury	occurred	•
Division of Vital Records,	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	3 Suicide 4 Homicide	6 Could no determine	be 28e. Plac	ce of Injury - A	At home, farm, ecify)	street, factory, o	office	20	28f. Location City or To	(Street and own, State)	Number or Re	ural Route Number,
	the Hospital or thin 24 hours after the Funeral Diru mpletely filled in	Medical ((Check 2 only one) 3	Certifying N	miner On the h	agis of examin	nation and/or in	vestigation, in my lge, death occurr	opinion, dea ed at the time	th occurred e, date and p	at the time, date place, and due to	and place, the cause(s	and due to the s) and manner	e cause(s) and manner stated. as stated.
	T With a second		29b. Signature and t		X	7			icense numb	375	73	29d. Date	e signed (Mon	th, Day, Year) [5, 7012 21802
	Sille		30. Name and addre	-	o completed ca	use of death	Po	loos	761	3 <	Salisbi	1 /c	ND -	21802
	Sta		31. Date filed (Month		32.	Registrar's S	ignature	New Y						
Di	Regist	ar	JAI	10350.	13 Au	m,	a. Go	ver						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 42550 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day December 26, 2012 1758 hrs **Medical Examiner** Hawkins James 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Foreian Director 51 04-11-61 Country) MD 220-80-4142 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1XX Yes 2 No MD NA Baltimore death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2503 Keyworth Avenue 21215 USA Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 African Yes Specify: American Pages I and 2 should be filed within 72 hours after of timent of Health and Mental Hygiene.
 Tatoft If item 27 is marked other than "outural", or or other fraumafic evoit, the Medical Examiner. 1 Yes 2 No specify: 3 Widowed If Yes, Give Year 4 Divorced <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Grade Laborer Bendix Company NA 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Hawkins, Jr. James Martha Ε. Tate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James C. Hawkins, IV. 3916 Rokeby Road Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 01-05-13 Randallstown, MD King Mem. Park Cem. 4 Donation 5 Other Specify 22. Name and Address of Facility Wylie Funeral Home P.A. gnature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line (Modical Death Immediate Cause (Final disease a. Asthma xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transi To the Hospital or Attending Physiciao: The law requires that the death certificate be executed within 24 butus after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Physician/Medical AMENDED 23a, pt. II, 27, per me, g937 3-4-13 sm X UNPENDED Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Month Day Fetal death 2 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ۾ 1 Yes 2 No 3 Probably 4 Unknown Narcotic Use Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other. DOA မှ 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 27, 2012 30. Name and address of person who completed cause of death (term 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31 Date filed (Month, Day, Year)

JANO 3 2013

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea 120 AM **Physician** 120 2012 tuanes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1 East University Parkway Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🔀 F 9, 1922 90 Auq. Director Maryland 218-26-4884 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 1 East University Parkway U.S.A.
14. Race - American Indian, 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) disabled disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph P. Hughes 2 Ethelvn unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William Baker 409 Washington Avenue Towson, attorney MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/2/2013 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge 22. Name and Address of Family tchell-Wiedefeld Funeral Home, Inc. 21. Signature of Fune 6500 York Road Baltimore, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, sician Physician/Medical the phy IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 9□Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed/ this certificate 2₽No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manher of Death 28c. Injury at Work? After t 1 🗹 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



29c. License number

Sutt

29d. Date signed (Month, Day, Year)

DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a, pt.II per doc. g934 12-12-12 yt. State of Maryland / Department of Health and Mental Hygiene AMEND #25, 27,28A-F. PER ME G935 1/3/13 TRT Certificate of Death Reg. No. State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Harry Norman Hagy, Jr. Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEDICAL CENTER BALTIMORE JUSEPH OWSON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 212-70-8419 56 **Director XX** M 2 □ F Jan 24, 1956 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Sparks 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 Rain Flower Path Unit 203 21152 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 244 No If Yes, Give 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2/1√2 No Specify. Specify: 3 Widowed 4XX Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired)
Truck Driver Elementary/Secondary (0-12) 8th College (1-4 or 5+) Potts & Callahan Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry N. Hagy, Sr. Dorothy Lugenbeel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Hagy (Sister) 18 Rain Flower Path Unit 203 Sparks 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 11/16/12 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service License 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. L. not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on lach line. Cardiac Arrest due to Hypoxia Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Priysician/ DAY Medical resulting in death) Due to (or as a consequence of): from mucus plug Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) CERTIFICATION APPROVED BY IMEDICAL EXAMINE rsician end e burlai-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The lew requires that the death certificate be 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery jo in the past 12 months? Day 1 Yes 2 No ate has been signed by the e page 2 should be detached to 9 Unknown P.O. Part II/Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Paraplegia due to MVC leading to Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available respiratory compromise prior to completion of cause of death? autopsy After this certificate requiring tracheostomy-hense mucus plug 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ္ရ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death

Natural

2 Accident 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d Describe how injury occurred subject driver of an SUV struck injury 5 Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 Yes 2 XNo ug.14,2012 Investigation 1:34 P 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number, City or Town, State) Middletown Rd near determined Roadway Fieldstone Ct Parkton, MD Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE TOWSON, MD KORi 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 29, 2012 8:00 P M EDNA M. HILL Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death OVERLEA HEALTH & REHAB BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 213-26-4581 Usual Residence of Dece 1 M 2 X F 83 **MARYLAND** APRIL 5,1929 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must to notified at filed within 72 hours efter death with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director BALTO. NOTTINGHAM MD. 1 🗆 Yes 2 😿 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **4327 PENN AVENUE** 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. \$ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) 12TH SCHOOL BUS CONTRACTOR HARFORD CO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ည be REVERDY JORDAN MINNIE REYNOLDS 1 and 2 should bot Health and Me item 27 is mark other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 4327 PENN AVENUE NOTTINGHAM, MD. 21236 CHARLES A. HILL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
important: If ite
any injury or ott Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1-3-2013 BEL AIR MEMORIAL BEL AIR, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD.21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Cardine CI YOU 4 themia 5 Minakes Medical resulting in death) Due to (or as a consequence of): Examiner per tensive Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury neamh 10475 • Hospital or Attending Physician: The law requires that the death certificete be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the ettending physicien and Hypertension 15 479 ettending physicien and for use es the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Meta static Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s autops nis certificate hi director, pege performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of Natural injury 5 Pending Director: A 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Yeertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 030494 1-2-2013 1630 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore BESHIND 716 maiden chaice lane

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last. 2. Date of Death 3. Time of Death ^{Day} 2<u>8</u> Physician/ December 2012 5:20 pm Elsie Holtzman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chevy Chase Montgomery Brighton Gardens Assisted Living 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 577-07-3976 1 M 2 X F March 23,1918 washington, DC sual Residence of Decedent 27 is marked other then "natural", or items 23a or 28a-f shov traumetic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase 1X Yes 2 No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 U.S.A. 5555 Friendship Blvd., #503 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗖 No Specify: If Yes, Give 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Should be filed within 72 h h and Mental Hygiene, 7 is marked other then "n Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sonia Yerovshefsky Abraham Loube 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31st Place. NW. Washington, DC 20015 Karen Holtzman - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Depertment of I Importent: If ite any Injury or of X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King David Mem. Grdns 12/31/2012 | Falls Church, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Dec. 27, 2012 Physician Aspiration Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami the ettending physician and thed for use es the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-trans. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FFMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 🗆 No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one R175265 ath (Item 23a) (Type, Print) 1768 Wisconsin Ave Suite 211 Betherda, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 16 5:00 AM ALBERT T. HURMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Anne Arundel 218 Inlet Drive Pasadena 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** 1**X**M 2□F Months Days 09 27 Hours Country) 86 1926 MD 217 20 4239 **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 X No MD Anne Arundel Pasadena 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral "natural", or items 23a U.S.A. 21122 218 Inlet Drive death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1. Yes 2 No 1943

If Yes, Give Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify Specify. White 3 X Widowed 4 ☐ Divorced 1946 Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Tavern/Resaurant Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Jefferson Sam Hurman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 1224 Rock Hill Rd Pasadena, MD 21122 Cathy Devilbiss - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Cross Cem 12/20/12 Baltimore, MD Signature of Function Price Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 21122 Pasadena, MD 169 Riviera Drive 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final month Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine π any, leading to immediate cause. Enter Underlying Cause (Disease or linjury anding physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day signed by the a 1 L Yes 2 L 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ohknown Division of Vital Records, been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has page 2 perform 2 🗌 No this certificate 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) director, examiner? Other: 4 \(\sum \) Nursing Home \(5 \) Residence \(6 \sum \) Other (Specify) ို 1 Tes 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa Manner of Death the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural iniury work? 5 Pending 1 \(\text{Yes} 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State

Registrar

d 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 0 3 2013

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death DELEMBER 22 7512 Physician/ 6.71 A M FRANK WILLIAM JESSE HILD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner GLEN BURNIE ANNE 4N OF SALTIMORE WASHINGTON MEDICAL CENTIS If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Director 217 16 1778 1 X M 2 □ F 05 14 1923 MD 89 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Glen Burnie MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21061 U.S.A. 228 Allwood Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1.1 Marital Status Black White etc. Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Trucking Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Meekins Francis Hild 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD 21061 228 Allwood Drive Beverly Wick - Daughter Baltimoře, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Olive Cemetery 12/28/12 Randallstown, 4 Donation 5 Other (Specify) Mt. 21. Signature of Funeral Source Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA21122 Riviera Drive Pasadena, MD 169 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ase or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ج</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No ☑ Natural 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and titl MD 22 2012 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person LABAI

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day Year)

JAN 0 3 2013

32. Registrar's Sig

12 Je

2-09628		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 42557
erry Jenkins		State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No.
Physicia ledical Exami	ın/	Jerry Jenkins 2. Date of Death Month Day Year December 18, 2012 3. Time of Death Month Day Year December 18, 2012
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore
Funeral Director		5. Social Security Number 5.78 – 76 – 2044
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-5 show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Dire	Usa No Indicate Indicate
Physician Wedical Examiner	er	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated) Due to (or as a consequence of): Due to (or as a consequence of): C
, P.O. Box 68760, ries that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Physician/Medical Examin	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 1
Records, P.O. The law requires that the frame requires that the frame rear signed by page 2 should be detach	Completed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic alcohol abuse 23e. Did tobacco use contribute to the cause of death? 1
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred
To the Hos within 24 h To the Fun completely	Medical	29a Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifier 29c License number 29d Date signed (Month, Day, Year) 29c December 19, 2012
		30. Name of didrer's of person who completed cause of death (Item 23a)

State Registrar

Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 20 per phys, G935, 1/3/2013, WS

State of Maryland / Department of Health and Mental Hygiene 42558 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Rosalie December 24, 2012 A. 7:15P Medical Examiner 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 7541 Belair Road Baltimore County Baltimore Social Security Number **Funeral** If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Hours Days 216 36 5073 September 13, 1940 Baltimore, Maryland Director 72 1 - M 2 X F Yrs Usual Residence of Decedent 28a-f shov death with the Maryland 10c. City. Town or Location Completed by Funeral Director notified Maryland Baltimore Baltimore County 1 🗌 Yes 2 🔀 No 0 10e. Street and Number 10f. Zip Code pe 10g, Citizen of What Country? 23a items 23a ner must b 7541 Belair Road 21236 LISA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 XX No Black, White, etc. 0 1 Never Married 2 X Married and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Ves Give 1 ☐ Yes 2 🙀 No Specify: "natural". 3 Widowed 4 Divorced Specify: Year or Dates White Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) the 4 Homemaker Housekeeping-Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ျှ Rocco Citro Edna Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Raymond Jachelski 7541 Belair Road Baltimore, Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) December 31, 2012 Weisburg Cemetery White Hall, Maryland 21. Signal re of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home INc Deather 7401 Belair Road Baltimore, Maryland 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physiciani aspipation DNEUMONIC Medical resulting in death) Examiner 6 years CIONSOA cystic COLCINOMA SUBMANDIBULAR Gland Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year signed by the at Id be detached f Pregnant at time of death g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been signe should be o Division of Vital Records, Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 XNo 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🔀 ER/Outpatient 3 🗌 DOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12/26/12 aust D0056414 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John N. Aucott MD 10755 Falls Road Suite 200 Lutherville, Maryland 21093 JAN 0 3 2013 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 31. Day 2012 1:29P Eloise M. Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** June 18, 1944 Baltimore, Maryland Director 212 44 4143 1 🗆 M 2 💢 F permit. Pege 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23e or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ¥ Yes 2 □ No Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4805 Sinclair Lane 21286 LISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian ģ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Environmental Services Johns Hopkins Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Moore Patsv Blunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3911 Loch Raven Blvd. Baltimore, Maryland 21218 Towanda J Smith (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1)(X) Burial 2 Cremation 3 Removal from State Parkwood Cemetery January 8, 2013 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service-Licenses 22. Name and Address of Facility Lassann Funeral Home Inc. 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCER disease or condition resulting in death) MONTH Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burlel-trensit or Attending Physician: The lew requires that the deeth certificate be executed Due to (or as a consequence of) ettending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical use es the IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 month Month signed by the et the deteched for 9 Unknown cate hes been signed by pege 2 should be detec Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? Completed by HYPERTENSION 1 Tes 2 No 3 □ Probably 4 □ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform To the Hospitel or Attending Physician: The within 24 hours efter deeth.

To the Funerel Director: After this certificate it completely filled in by the funeral director, pag 2 No 1 🗌 Yes 25. Was case referred to edical Be 26. Place of Death (Check only one) è Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 🖪 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22^{Day} Physician/ Menth 2072 1:40 pM Jordan Ruth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore 1346 Kitmore Road If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 212-18-5302 1 □ M 2 🖺 F **Director** 94 VA 3/8/1918 . Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland rector 1 Yes 2 No Baltimore N/A MD ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21239 1346 Kitmore Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th <u> Housewife</u> Domestic ulth and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown မ Lucy Glover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 Atlon Ct. Rosedale, MD Charlene Jordan-Daughter 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any Injury or o 1 🕱 Burial 2 🗌 Cremation 3 🔲 Removal from State National Cemt. 12/31/12 4 Donation 5 Other (Specify) Laurel, MD 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H VU 1101 E. North Avenue Baltimore, MD 21202 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause in each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami After this certificate has been signed by the attending physician and if funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? Yes No 1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 Nursing Home Residence 6 Other (Specify) မ 21 No 1 Inpatient 2 ER/Outpatient 3 IDOA by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending s after death. 1 Tyes 2 🗆 No 2 Accident Investigation ☐ Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in within 24 hours af

To the Funeral Di

completely filled i Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Deborah E. Johnston 2012 DECEMBER Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Greneral HUSDITA Maryjand HMOYE n/a If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min (Month, Day, Year, 212-58-3347 63 Director 1 🗆 M 2 🗶 F Maryland Nov. 12, 1949 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Examiner must be notified 28a-f 1 X Yes 2 No Maryland n/a 10e. Street and Number 10g. Citizen of What Country? 5 23a Funeral 21206 5009 Frankford Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1. Marital Status Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Yes Yes Yes, Give 2 **X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home Home Maker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Bernard Cohen Jean Unger 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 639 Eoxelder Drive Edgewood, Maryland 21040 Sharon Ramsey/sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or or 1 Burial 2 K Cremation 3 Removal from State Metro Crematory, inc. 12/28/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) re of Funeral Service Licensee Sternanie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road Baltimre, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ Obstructive disease or condition Medical resulting in death) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or injury that initiated events Mrinary Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the as attending IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year 9 Unknown P.O. I been signed by should be detac Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 7005,5 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Yneumonia 24a. Was an has autopsy performed Hospital or Attending Physician: The certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒️No 26. Place of Death (Check only one) Be မ 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 🗷 Natural 5 Pending thin 24 hours after death.

the Funeral Director: Aff
mpletely filled in by the ful Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one) 29b. Signature and title of certifier 89783 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

32. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 12562

		1- For State Certificate of Death Reg.	2012 No.	42002
Physiciai fedical Examin	1/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month D		3. Time of Death 1600 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Bayview Medical Center 4b. City, Town, or Location of Death Baltimore	4c. County of Death	
Funeral Director		5. Social Security Number 218-92-5849 6. Sex 1. Age (In yrs. last birthday) 1. Age (In yrs. l		place (State or htry)Maryland
nd show any ce.	Ī	Usual Residence of Decedent 10a. State		10d, Inside City Limits 1 XXYes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	iss. Of our and remain	. Citizen of What Countr J $_{f s}$ S $_{f s}$ A $_{f s}$	ry?
er death wi	本 I	11. Marital Status 1	14. Race - America White, etc. Ameri Specify: India	ican an
036 thin 72 hours ne. r than "natur ledical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker	Own Home	dustry
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene it: If item 27 is marked other than ' other fraumatic event, the Medical	a R	Mitchell Hammonds Lorna Barnes		Zin Cordo)
MD 2, and 2 should alth and M im 27 is m armatic c		19a. Informant's Name/Relationship (Type, Print) Fartle Barnes, Jr. Uncle 7612 Brightside Avenue Roseda 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date		nd 21237
imore Pages 1 nent of H ant: If i		are promotors or other place)	Hanover. M	arvland
Ball Ball Ball Ball Ball Ball Bart Bart Import		mithal marguelle— 23a. Part I. Enter the disease, opcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest	ce, Marylan	d 21214 Approximate Interval
Medical Examiner	1	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Between Onset and Death
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60, ate be exect hysician an e burial - tr	Medical	□ AMENDED 23a,27,28a-f,per me,g936 2-8-13 sm FFEMALE: 23c. if yes, outcome of pregnancy	23d. Date of delivery	
lox 687 leath certificate at the for use as the			M onth Da	,
B, P.O. E	<u>a</u>	1 Yes	acco use contribute to th	
Division of Vital Records, P.O. Is a or Attending Physician: The law requires that the safer death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed	24a. Was an autopsy perform 1 ✓ Yes 2	prior to co ned? death?	mpletion of cause of
Vital Rec hysician: The I this certificate	o Be	25. Was case referred to medical examiner? 1 V Yes 2 No 26. Place of Death (Check only one) 1 Place of Death (Check only one)	esidence 6 Other:	
ion of vitending Ph. leath. tor: After ti	ation: T	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe ho		
Divisior To the Hospital or Attent within 24 hours after death To the Fineral Director; completely filled in by the	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Str or Town, Sta Baltimor		
Fo the Hos within 24 h Fo the Fun	edical	23a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause((Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date an and manner stated.	nd place, and due to the	cause(s)
	Σ	255. Signature and this of servines	29d. Date signed (Mont December 27, 20	
- Africa		30. Name and address of person who completed cause of death (Item 23a) / Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		
Sta Registi				
DHMH 17 Rev 1/20	01	OMIGINAL	08	THE STATE OF THE S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42563 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Henry Ivor Jones Year 2012 Month (2: (7 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death (tru ure SINAI HOSPITAL BA Itmure Cil N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) March 2, 1924 Days 509-38-5425 Director **X**X M 2 □ F 88 Wales Usual Residence of Decedent in the major of the properties of the second Director 10a. State 10b. County 10c. City, Town or Location the Marylend 10d. Inside City Limits MD N/A Baltimore Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pege 1 end 2 should be filed within 72 hours effer deeth with 1 Department of Heelth end Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Iteme 23e upon Injury or other treumetic event, the Medical Examiner must be once. Funeral 21209 U.S.A. 2211 West Rogers Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 TVNo 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Š 1 ☐ Yes 21 No Specify: If Yes, Give White Specify: XXX Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 5 + College (1-4 or 5+) Private Practice Physician Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katherine McKillop Thomas Henry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bruce Jones (Son) 4902 Wilmslow Road Balto, MD 21210 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XXX Cremation 3 Removal from State 12/27/12 Atlantic Crematory Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Fup 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 Part 1. Enter the disease, of domplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the dis Approximate Interval Between GasTROINTESTinal Immediate Cause (Final disease or condition Bleeding Onset and Death Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physicien: The lew requires that the deeth certificate be executed by the ettending physicien and steched for use as the buriel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day defer death.

Director: After this certificate has been signed by the experience of the first things of the control of the con 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 A No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛮 No မြ 1 Inpatient 2 ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1) Natural 2 Accident (Month, Day, 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be within 24 hours efter de To the Funerel Directo completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the F only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 00545 Dec 2012 Jolly 30. Nameland address of person who completed cause of death (Item 23a) (Type, Print) SINAI HOSPITAL Ke In UR TLED EBIZ 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER. Physician/ SHIRCEY 10:32 PM KEEHER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTINDDE-WASHIDHTOM MEDICAL CENTER GLEH BURHIE I JOHUMA HHA If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Director 1 M 2 M 18 MI reb Usual Residence of Decedent in than "netural", or itsms 23e or 28e-f show the Medical Examiner must be notified at permit. Page 1 end 2 should be filed within 72 hours efter deeth with the Merylend Department of Heelth and Mental Hyglene. Important: If item 27 is marked other than "netural", or itsms 23e or 28a-f sho 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No 11 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. δ 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) - Employed item 27 is marked othe other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cren 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Injury or 4 ☐ Donation 5 ☐ Other (Specify) taven Signature of Juneral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 20249 414040349 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): tor: After this certificate has been signed by the ettending physician and the funeral director, page 2 should be deteched for use as the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burlal-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Vear Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESAD 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No **Division of Vital** Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
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State Registrar 301 HOSPITAL DRIVE, ELEH BURHIE, MO 20161

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUILLERMO JOSE GIRNERECO

31. Date filed (Month, Day, JAN 0 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 31 ZOIZ Physician/ Month 04 M Stephen Kolb Jr. Recei Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Upper Chesapeake Medical Center Bal Air . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 217-50-5758 Director 1 X M 2 □ F 66 September 1,1946 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28e-f show the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Nottingham Baltimore Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8636 Manorfield Road 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mantai Hygiena. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bethlehem Steel 12 years Water Quality Technician years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Theresa Michalski Peter Stephen Kolb Sr. Jean 1 and 2 sh. Jeanth and Importent: If Item 27 is many injury or other 2 once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia M. Phagan sister 130 Summer Woods Way, Owings Mills, Maryland 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Cem. 20a. Method of Disposition 20c. Location - City or Town, State January 4 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2013 Baltimore, Maryland Signature of Funeral Service Licensee CONTENIOR TUNETAL Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise set or complications that caused the deat 1.00 not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Immediate Cause (Final Decembe Physician/ disease or condition resulting in death) Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury Due to (or as a consequence of) sician end burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ending physician usa as the burlal Physician/Medical or Attending Physician: The law requires thet the death certificate be attending plant of for usa as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Day signed by tha a ld be datachad f Division of Wital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown To the Hospital or Attending Physician: The law requires within 24 hours a 'er death.

To the Funeral Director: After this certificeta has been sign on the Funeral Director of the funeral director, page 2 should I complately filled in by the funeral director, page 2 should I 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December Alice E. Kelly 2012 9:47 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland **Funeral** Months Days 215-16-1945 Hours Min. larch 25, Director 1922 1 🗆 M 2 🕱 F 90 Yrs. Usual Residence of Decedent r then "natural", or items 23a or 28a-f show the Modeal Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 🛣 Yes 2 🗌 No N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3839 Bonview Ave. 21213 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should te filed within 7. Department of Health and Mental Hygiene. Importent: If item 27 is rearsed other then any Injury or other traur atte event, the M. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ashby P. Smith Alice Drurey 19a. Informant's Name/Relationship (Type, Print)
Michael P. Kelly- Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44665 Via Venice Laquinta, CA 92253 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Most Holy Redeemer Cem 1/2/2013 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signatura If Funeral Service Licenses <u>9705 Belair Rd. Nottingham, MD 21236</u> 23a. P. 71. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Breast Physician/ disease or condition resulting in death) en Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use es the burlel-trensit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 WNo Division of Vital e a 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 12 No 2| 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospitei or Attending Phy within 24 hours efter death.

To the Funeral Director. After this completely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 58303 December 28 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

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32. Registrat's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42567 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Month Claude 15egle 0314 2012 December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center BelAir 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 12/23/1937 1 🎦 M 2 🗆 F Director 228-46-9025 75 Virginia Usual Residence of Deced 28a-f shov 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits notified at Director 1 Xyes 2 No Aberdeen Maryland Harford 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral USA 21001 7 Chesapeake Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🄀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ð 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 N Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medico 16b. Kind of Business/Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) private industry mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Mary Belle Welch Robert L. Kegley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Chesapeake Ct., Aberdeen, MD 21001 Mark Kegley (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/3/2013 Aberdeen, Maryland Grove Presbyterian 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. i. i.an. disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury 1 that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Pregnant at time of death 2 No 9 Unknown Unknown o Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) funeral ð 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Division within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D0069723 12/31/12 MD Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeako Dr. Belair, mD 21014 Daniel Horny 10 1

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 December 12:15 A.M Medical Ethel Marie Kable 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, January 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours 215-30-1463 Director 1 □ M 2 😾 F 78 Yrs Pennsylvania Usual Residence of Decedent 1934 permit. Page 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hjury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Lutherville Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21093 11 Alston Road America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify white Specify: 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles J. McGeehan, Jr. Gladys Lou Roll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lutherville, Maryland 21093 Mr. William H. Kable, Sr./hus. 11 Alston Road 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State January 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evants, Funday or other place) Forest Hill, Maryland 2013 Chapel-Bel 21. Signature of Planeral Service Licensee 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. NO Timonium, Maryland 21093 2325 York Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ * Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami or Attanding Physician: The law requires that the death certificate be executed ing physician and e es the burlai-trans Due to (or as a consequence of): Physician/Medical been signed by the attending should be detached for use ex IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Part II. **Other significant conditio**ns c**ont**ributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗋 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy perform 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 5D; ce 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 🗀 Pending Natural Accident work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0071287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St. #4105, Balthware, MD 21204 31. Date filed (Month, Day, JAN 0 3 32. Registrar's Signatur

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kalama 10:53 PM Physician/ Month amue Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care- Rossville Rossville 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Aug. 15, 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Nigeria 1 Ϊ M 2 🗆 F Months Days Hours 424-17-7698 62 1950 **Director** Usual Residence of Decedent show 10a. State 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 Somerville Court Apt. F 21234 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Judiciary Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Services 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thompson Kalama Iwo Grand 19a. Informant's Name/Relationship (Type, Print) 21234 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kaine Kalama- Wife Somerville Court Apt. F Parkvill, 20b. Place of Disposition (Name of UNK cemetery, crematory or other place) UNK 20a. Method of Disposition 20c. Location, - City or Town, State Date UNK Department of H Important: If ite any injury or ott once. Page 1 1 XBurial 2 Cremation 3 Removal from State Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death meglate Cause (Final Physician/ ise e or condition r suring in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Other (specify) Pregnant at time of death signed by the a 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🔲 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medicar examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Deat Certificate: 28c. Injury at 28d. Describe how injury occurred work? injury Natural Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lagvenkar

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ă	To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	alc									
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	Stat	te.	31. Date filed (Month, Day, Year)	32. Registrar's	Signature						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RAC 30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Paltimore Muest Kandal Stowy Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 13-36-6222 Director 1 JM 2 DF 10 d Mentel Hygiene. merked other then "neturel", or items 23e or 28e-f sho metic event, it e Medical Exerciner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Des 2 No Cuto MMOU 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 1/10
If Yes, Give
Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BOC 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 01 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည essie traumetic . Pege 1 end 2 should b tment of Heelth end Mer tent: If Item 27 is merk 19a. Informant's Name/Relationship (Type, Print) eal 21228 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Importent: If ite eny Injury or ot 1 Defurial 2 Cremation 3 Removal from State altimore 2013 4 ☐ Donation 5 ☐ Other (Specify) Jawn 21. Signature of Funeral Service Livense a 23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiritory arrest, shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ AMOU disease or condition resulting in death) Medical Due to me as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): S be executed ettending physician and I for use as the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day To the Hospitei or Attending Physicien: The lew requires that the dee within 24 hours effer deeth.

To the Funerel Director: After this certificate has been signed by the e completely filled in by the funerel director, page 2 should be detached it P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 10No Other: 4 Nursing Home 5 Residence ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 🗌 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type 693 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ane Physician/ Sas Dasa December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sinai Emergency ROCIN Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days (Month, Day, Year) 04/10/1942 Months Hours Min. 217-38-9852 Director 1 🗆 M 2 🔀 F 70 N. Carolina 28a-f show 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21215 4818 Cordelia Avenue Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner munor or other traumatic event, the Medical Examiner munors or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ Yes 2 X No Yes, Give 1. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Rusiness/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Home Cook 11th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Oscar Cartwright Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Littlebrook Ct. Windsor Mill, MD. 21244 Leslie Renee Lewis/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Department o Important; If any injury or once, Dundalk, Maryland 12-27-12 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licens, e 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd.Baltimore, MD.21215 le rach Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardi CI disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed poly physician and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: been signed by the attending should be detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy death? performed? 2 • No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: 2 **N**o 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury 28b. Time of 8c. Injury at s after death.

I Director: After the od in by the funeral 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 Yes 2 No 1 Natural 5 Pending AccidentSuicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 within To the 29d. Date signed (Month, Day, Year) 29c. License number D6012729 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 Garrison State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney A - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lower 12 10:00AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Simi Hospital of Baltimore Bainmore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-26-9345 (Month, Day, Year) Days Hours Min. Director 1 □ M 2 🖫 F City, Town or Location 28a-f show 10a. State 10d. Inside City Limits 10c the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗀 🗐 o 10e. Street and Number ō 10g. Citizen of What Country? Funeral Items 23a USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married "naturel", or δ 1 ☐ Yes 2 🔀 o Maryland 21215-0036 within 72 hours after Specify: 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 to f Health end Mental Hygiene.
If item 27 Is marked other than "nor other traumatic event, the Mical College (1-4 or 5+) omestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle permit. Page 1 and 2 should be Department of Health end Ment Important: If item 27 Is marke any Injury or other traumatic o cnot Boute Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural 6wynn Oa MD 21207 rephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fune Al Service Licensee ervices mD 21229 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest failure. List only one cause on each line. 23a. Part 1. Enter the shock, or hear Approximate Interval Between nset and Death Immediate Cause (Final Physician/ erebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> icate has been signer 7, page 2 should be o 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death.

Funeral Director: After this certificate the fellowing filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 Nopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 1 🗌 Yes ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. rpletely Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the I

complete only one) 29b. Signature and title 29d. Date signed (Month, Qay, Year) 30. Name and address ss of person who completed cause of death (Item 23a) (Type, Print) Belvedere are Baltimore MD 21215 FOREMan M.D. W. 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES JOSEPH LINARDI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner OU 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Hours 219-22-3661 Director 1 XM 2 □ F 85 January17,1927 Maryland Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 West 40th Street 21211 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married δ 1 ☐ Yes 2 ☐ No Specify: white Completed 3 Divorced 4 Divorced Year or Dates WWT 7 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 Lithographer Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve James Joseph Linardi Grace Vicchio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 West 40th Street Baltimore, MD 21211 <u>Marie Linardi</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/03/2013 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery Pikesville, MD 21. Signature of Funeral Service Ligensee, 22. Name and Address of FMittchell Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ EUMONIA disease or condition Medical resulting in death) [']Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ed by the attent detached for u in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? certificate has been signed irector, page 2 should be de Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No the Funeral Director: After this Communicately filled in by the funeral director, pe Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}} \) 1 \(\text{\text{\text{Residence}}} \) 6 \(\text{\text{\text{\text{Other}}}} \) Other (Specify) 2 X No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 XI Natural 5 Pending 1 Yes 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2

To the I

complete only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 12-30-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 5:43 A December 2012 Edith Faye Luaces Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Director 219-40-8638 1 M 2 X F Yrs. Aug 15, 1937 75 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
The stream at 21 served other than "ratural", or Items 23a or 28e-1 show other traumetic event, the Medical Examirer must be notified as 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Ellicott City 10e. Street and Number 10g. Citizen of What Country? Funeral 539 Oella Avenue 21043 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 5:43 a.m ۾ 1 ☐ Never Married 2 🏻 Married Maryland 21215-0036 1

Yes 2

No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates. Spanish 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Medical n/a Electrologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Toscano Itzel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Depertment of Health ar Important: If Item 27 is any injury or other trau Maria Flora Carter/Daughter 539 Oella Avenue, Ellicott City, MD 2<u>1</u>043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State DECEMBER 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Spec Atlantic Crematory 12/28/2012 Glen Burnie, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 re of Funeral/Service Lo Clary 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediat Cause Final disease Condition Priysician/ disease condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir attending physicien and I for usa as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funeral Director: After this certificate has been signed by the attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death EDITH LUACES 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 👿 No Day Month Pregnant at time of death 5 Other (specify) Year cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [호 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' After this certificate in funerel director, pag 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE ဥ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending ours after deeth. eral Director: Af filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. complately Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

HM

Registrar
DHMH 17 Rev 06-2011

2300 DULANEY VALLEY RD.

TIMONIUM,

MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

32. Registrar's

TRACIE L. MORGAN,

JAN 0 3 2013

31. Date filed (Month, Day, Year)

12-09924 Autumn Lang

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician Medical Examin	1/	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year r 28, 2012	3. Time of Death 0331 hrs
Wieulcai Examini		AUTUMN LANG 4a. Facility Name (if not institution, give street and num	ber)	4b	. City, Town, c	or Location o		r 28, 2012 4c. County of Dea	
		University Hospital			Baltimore			N/A	
Funeral Director		213-81-2313 1 M 2 XF	. Age (In yrs. la	ast birthday) 5 Yrs.	Months Da		24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. B Fore / 2007	irthplace (State or ign MARYLAND ountry)
Au a	-	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location)				10d. Inside City Limits
	۱	MARYLAND N/A		BAI	TIMORE				1XXX Yes 2 No
Maryle r 28a-f		10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	untry?
with the Maryland us 23a or 28a-f sho be notified at once		841 CARROLL STREET 11. Marital Status 12. Was Dece	dent Ever in II	S 13 W/2e	212		in? (Specify Yes or No	U.S.A.	rican Indian, Black,
leath w	runerai	1 Never Married 2 Married Armed For 1 Yes					Puerto Rican, etc.)	White, etc.	rical indian, black,
£ 191	2	3 Widowed 4 Divorced or Dates:			es 2X N			Specify: BLA	
136 thin 72 hours a re. than "natura edical Examin	<u>g</u> -	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)			Usual Occupa t of working lif		ind of work done use retired)	16b. Kind of Business	/Industry
036 ithin 7, ne. redical	Сощріете	Oyrs	,	N/A	1			N/A	
		17. Father's Name (First, Middle, Last)					s Name (First, Middle,		
imore, MD 21214 Pages I and 2 should be fil ment of Health and Mental I ant: If iten 27 is marked or other traumatic event, 1	9 0	AUBREY LEE LANG III 19a. Informant's Name/Relationship (Type, Print)		19b. Mailing A	ddress (Stre		IA YVONNE I ber or Rural Route Nur	HICKS mber, City or Town, Stat	e, Zip Code)
e, MD land 2 sho Health and item 27 is rtraumati		Lakia Y. Hicks/Mother						Maryland 2	
imore, MI Pages 1 and 2 s nent of Health a ant: Litem 27 or other traum		20a. Method of Disposition 1 Burial 2 XX Cremation 3 Removal from		Place of Disposition of of Dispos		emetery,	Date	20c. Location - City of	r Town, State
Baltimore, permit. Pages 1 at Department of He. Important: Uite injury or other tr		4 Donation 5 Other Specify: 21 Sign ture of Funéral Servicer Live see	ME	TRO CREN			01-05-13	BALTIMORE,	
Bal permi Depa Impo injur	V	21. Sign ure of runeral service pressee			LIAM C			Y FUNERAL H	OME P.A.
Physician		23a. Part I. Enter the disease, o complications that cau failure. List only one cause on each line.	sed the death.					rest, shock, or heart	Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death) aComplica Due to (or as a complication)			riatria	atum			Death
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Box 68760, death certificate be executed the attending physician and ed for use as the burial - transit	81018	1 Yes 2 No 9 Unknown 9 Unknown	nt at time of dea	oth	(Specify)				
		Part II. Other significant conditions contributing to c		esulting in the und	lerlying cause	given in Par	t I. 23e. Did t	obacco use contribute to	o the cause of death?
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of Vital Is Physician: the this certificant of the configuration of the	ă	25. Was case referred to medical examiner? Hospital: 1 Inc.	patient 2	ER/Outpatient		Othor	Check only one) Nursing Home 5	Residence 6 Other	er:
ding Phys After thi funeral di	1	27. Manner of Death 28a. Date of	Injury	28b. Time of Inju		ury at Work?		how injury occurred	
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Division (spital or Attending sputal or Attending spital or Attending neral Director: Af filled in by the fun		Suicide Could not be determined (Specific)	of Injury - At ho	ome, farm, street,	factory, office	building, etc	28f Location (or Town, S		ural Route Number, City
0 - H >		29a. Certifier 1 Certifying Physician: To the best	of my knowledg	ge, death occurre	d at the time, o	date and plac	ce, and due to the cau	se(s) and manner as sta	ited.
To the How within 24 h To the Fur		one) 2 Medical Examiner: On the basis of and manner sta	examination ar	nd/or investigation	n, in my opinio	n, death occ	surred at the time, date	and place, and due to t	he cause(s)
	Ε	29b. Signature and title of certifier				.M.E.		29d. Date signed (Me December 29, 2	
4	L	30. Name and address of person who completed cause	of death (Item	23a)	J 0.0	.191. 🗠 .		December 29, 2	
4		Laron Locke MD. Assistant Medical		,	more Stre	et, Baltim	ore, MD 21223		
Stat Registra	e	JAN 32 20 (3") Description 32. Reg	strad's Signa	arke					

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	Physicia	an/	1. Decedent's Nam		•							2. Date of De	eath	ay	Year	3. Time o	f Death
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4	Examir	ner	4a. Facility Name (ii							Location	of Death		4	c. County	of Death		
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\$	Page Tent o		1 ☐ Burial 2 4 ☐ Donation	☐ Cremation 3 5 😡 Other (Spe	□ Removal from ecify)Entomb		emetery, ghvi	ew Mem.	ther place Gar	dens	Jan.	3, 113	 Fal	.lsto	n, Ma	arylan	đ
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2	certificate nding phy	Me	IF FEMALE:					· · · · · ·			-						
Arno	DOX DO/ON death certificate e attending physed for use es the	ian/	23b. Was decedent in the past 12		23c. If yes, out	come of pregna Birth 2 ☐ Feta		3 Ectopic	oregnanc	y					te of delive	•	
	the at	ysic	1 Yes 2 I	☐ No	4 ∐ Pregr 9 ☐ Unkn	nant at time of own	death	5 Other (sp	ecify)					Мо	nth	Day	Year
	requires that the death certificate requires that the death certificate been signed by the attending phys should be detached for use as the	Completed by Physician/Medi	Part II. Other signif	ficant conditions	contributing to de	eath but not res	sulting in t	he underlying	ause giv	en in Part	1.	23e. Did 1	tobacco	use contr	ibute to th	e cause of c	leath?
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4	Attending Physicien: or death. sctor: After this certific by the funeral director.	To Be	examiner?	No.	Hospital:	patient 2 🗆	EB/Outr	atient 3 □ D	Otho	-		me 5 🗆 Resi	idenco	6 T O#-	r (Specific	······································	
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]	endir eath. or: Af	lica	1 Natural 2 Accident 3 Suicide	5 Pending Investigat	ion	ii, bay, roar)	lingo	, м	work'	Ýes 2□	No .						
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Č	the Hospitel or hin 24 hours afte the Funerel Din Tpletely filled in	Medical	(Check /2	○ L Medical Exa	miner: On the basi urse Practitioner:	is of examinatio	n and/or ir	vestigation, in	ny opinio	n, death oc	ccurred at	the time, date	and plac	e, and due	to the car	use(s) and ma	nner stated.
0	Vithi To t		29b. Signature and						. License			10		ate signed			_
30				- Ull	4			1)	00)63	30	47		121	79	112	
32	3		30. Name and addr	ess of person wh	o completed caus	e of death (Iten	23a) (Typ	e, Print))			Λ-	· · ·	201 n	No.	ווגור ר
0			31. Date filed (Mont	th Day Year	janska	ya c	<u> </u>	Oppe	V C	nes	cyce	and.	Uil	06 r	KIF	114,117	ノムロソ
Ď	Sta Registr		JAN 0	3 2013	General	egistra s Signa	ale										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:07 Ann ecember Medical ne in not institution, ty, Town, of Location of Death 4c. County of Death Examiner BALTIMORE CITY Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 208-40-8404 **Director** 1 **X** M 2 □ F Yrs 09/30/1951 CONNECTICUT 61 or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 1X Yes 2 No MD ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10g, Citizen of What Country? Funeral Items 23a GENTRY COURT 21403 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black White etc. 6 þ 1 Never Married 2 Mamed Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates WHITE 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BOATING REPAIRMAN 12 Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ပ္ **JOHN** LLOYD PHOEBE WADDELL E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 Is eny Injury or other trau ASHFORD DRIVE, AVON, CONNECTICUT 06001 DAVID LLOYD/ BROTHER 15 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BAYVIEW CREMATORY 12/31/12 BALTIMORE, MARYLAND Pare and Address of Facility INC. FUNERAL HOME 901 EASTERN AVENUE, BALTIMORE, MD . Signature of Funeral Se vice Licenses 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sconlaneous Physician Intracranial hemorr hase disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner artension Sequentially list conditions, Due to (or as a consequence of): Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death ceruinday to account within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2012

State

30. Name and address of person who completed

ORNBL

31. Date filed (Month, Day Year)

DHMH 17 Rev 06-2011

Registrar

23a) (Type, Print)

12-0984	15
Vernon	Ludwig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

non Ludwig	1	State	ate of Mar	yland / De	epartn C <i>ertifi</i> d	nent of cate of	Health Death	and	Mental	Hyg		Reg. No.	2	01	2	4257
Physicia		Registrar 1. Decedent's Name (First, Middle	e,Last)							2.	Date of De		Year			of Death
dical Exami	-1111	Vernon Walter		, Sr.							Decembe	er 25, 3	2012			8 hrs
		4a. Facility Name (if not institutio	n, give street an	d number)		41			ocation of De	ath		40	. County o	f Death	1	
		Saint Agnes Hospital					Baltimor							J o Bis	thalass i	State or
Funeral		5. Social Security Number	6. Sex	7. Age (In			If Under 1 Months	Year	If Under 24 Hours	h din	8. Date of B			Foreig	n	- 1
Director		219-40-0132	1K M 2	F	6	7 Yrs.	WOITE	Days	Thouse .		06/15,	/194	5	Co	untry) [\	laryland
	- 1	Usual Residence of Decedent													I 10d In	side City Limits
409		10a. State 10b. County				vn or Locatio										Yes 2 No
* .	_	MD		B	alti	more (City			_						Tes ZNO
Aaryland 28a-f shnw 3 at once.	돯	10e. Street and Number					10f. Zip Co	ode				10g. Cit	izen of Wh	at Cou	ntry?	
rith the Maryland 123a nr 28a-f shnw 2 notified at once.	Director	3111 Strickla	ind St.				2122	23				USA				
vith ti	ᇹ	11. Marital Status		Decedent Ever	r in U.S.	13. Was	Decedent	of Hispa	anic Origin?	(Spec	cify Yes or N	0-	14. Race White		ican Ind	an, Black,
ath v item	Funeral	1 Never Married 2 M	arried Arm	ed Forces?	No	If Ye	es, specify C	cuban, I	Mexican, Pu	ento r	ican, etc.)		VIIII		44.	
rer de	五	3 X Widowed 4 Div	orced If Yes, Giv				Yes 2 X						Specify:		ite	
urs af tural	ğ	15. Decedent's Education (Spe	or Dates: ecify only highes	t grade complet	ed) 16	a. Decedent	's Usual Oo	cupatio	on (Give kind	of wo	rk done	16b.	Kind of Bu	siness/	Industry	
2 hou	黛	Elementary/Secondary (0-12)	Colle	ge (1-4 or 5+)	\neg	auring mo	St of Workin	ıg ıllə. L	OO NOT use	10010	۵)					
36 hin 7 them	힐	10				Cabine	et Mak	cer_				C	arper	itry		
d with	Completed	17. Father's Name (First, Middle	, Last)					18	B.Mother's N	lame (l	First, Middle	, Maide	n Surname)		
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MD and 2 sho alth and m 27 is	1	Vernon Ludwig	g, Jr./	Son		527 (Old Ri	Lver	side	Rd.	, Bro	okly	n Par	<u>k,</u>	MD 2	21225
		20a. Method of Disposition		21.1		e of Disposi		of cem	etery,		Date	20c	. Location ·	· City oi	r town,	State
Baltimore, permit. Pages 1 ar Department of Her Important: If ite		1 Burial 2 Crematio		val from State		ntic (torv	1	2/3	0/201	2 G	len E	durn	ie,	MD
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- H	X	events resulting in death) Last	Due to (d	or as a consequ	ence of):											
executed an and al - transit			d							-						
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Box 68760, death certificate be the attending physical of for use as the buri	sician/Me	IF FEMALE: 23b. Was decedent pregnant in		f yes, outcome	of pregnar		etal death	з Г	Ectopic p	reanar	ncv	ľ	3d. Date o Month	(delive	Day	Year
68 certific ding	lä.	past 12 months?	' -	Live birth Pregnant at tim	e of death	~ ' -	her (Specif	L.		9	,					
eath c	Sic	1 Yes 2 No 9 U	nknown 9	Unknown		٠ <u>ــــ</u> 0	iller (oposii					- 1			_	
D. D. D. D. D. D. D. D. D. The darked ached	P. F.	Part II. Other significant cond	litions contribu	uting to death bu	ut not resu	ulting in the u	underlying	cause g	iven in Part	l.						use of death?
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cords, law required has been a 2 should	를									_	pe	itopsy erformed		death?)	
Division of Vital Records, tal or Attending Physician: The law requir staffer death. al Directure: After this certificate has been sill or the funeral director, page 2 should be led in by the funeral director, page 2 should be	E											s 2 🗸	No	1 📗 `	Yes	2 No
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lon (lendin eath. nr: A	🚊	1 Natural 5 Pe	nding	(11	Yes 2 N	10						
isic Atte er dea	ig.	2 Accident Inv	vestigation 28	e. Place of Injur	y - At hom	ne, farm, stre	et, factory,	office b	uilding, etc.			n (Stree n, State		ber or I	Rural Ro	ute Number, City
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ospir hour		29a. Certiller	Physician: To	the best of my k	nowledge	, death occu	rred at the	time, da	ate and plac	e, and	due to the o	ause(s)	and mann	er as st	tated	
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To t	led	29b. Signature and title of cert	and ma	anner stated.					se number				d. Date sig			
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100		N-0L.			11 (2:											
1.		30. Name and address of pers) W Balt	imore	Street F	Baltin	nore, MD	2122	3			
		Donna M. Vincenti,		tant Medica			. vv. Dail									
	State	31. Date filed (Month, Day, Yea	n12 A	32. Registrar's	signature \$	/										

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OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Pecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ *Cember 10:25PM Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) Examiner Hvenue NAYWE vaine Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral Director** 1 M 2 F 87 or than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at 10c. City Town or Location 10b. County 10d. Inside City Limits filed within 72 hours efter death with the Maryland Director 1 🗌 Yes 2 📈 o 10e. Street and Number 10g. Citizen of What Country? Funeral 21207 USA ame Was Decedent Ever in U.S. Armed Forces? _ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 1 Yes 2 No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2**7**5500 Specify: 3 Nidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busin permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event service." (Specify only highest grade completed) Give kind of work done during re. DO NOT use retired) College (1-4 or 5+) Be Name (First, Middle, Last, hanc ac ddress (Street and Number or Rura 19a Informant's Name/Belation City or Town, State, Zip Codel Baltimore, 20a. Method of Disposition 20b. Place of Disposition 20c. Location - City or Town, State Purial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Ho. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Poset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) eel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit To the Hospital or Attending Physician: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ğ Month Day sate has been signed by the a page 2 should be detached it P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\frac{1}{2} \text{Residence} \) 6 \(\subseteq \text{Other} \) Other (Specify) 1 🗌 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Natural Accident 5 ☐ Pending _ Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature nd title of certifier 29c. License number Jan 2,2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) chwar MD Newland au 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 43 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore OWSO 40 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Days Hours Min. Director 1 - M 2 XF 629 permit. Page 1 and 2 should be flied within 72 hours eftar death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28e-f show with Injury or other treumetic event, the Medical Examiner must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 ☐ No Daltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 N No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 3 Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) eticiar Baltimo Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ KO oinson 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgewood Jackey VINA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State etery, crematory or other place) 2013 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 1202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to infinedate cause. Enter Underlying Physician/Medical Examiner Due to for as a nonsequence of within 24 hours efter death. To tha Funerel Director: After this certificete has been signad by the attending physician end completaly filled in by tha funerel director, pege 2 should ba deteched for use as the burial-transit • Hospitel or Attending Physician: The lew requires that the death certificate be executed 24 hours effer death.
• Funeral Director: After this certificate has been signed by the attending physician end Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 🔲 Yes 2 🕅 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of autopsy 1 ☐ Yes 2 🔯 No 1 ☐ Yes 2 ☐ No 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 M No Hospital: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 ☐ Residence 6 🖾 Other (Specify) VVOSOL CL 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifie 29b. Signatu December 272012 \sim 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W MANUSS NOMAR 60

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State Registrar 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0645 ARQUEZ 28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Linthicum Heights Anne Arundel Tate Hospice House If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Director 556-40-2129 1 X M 2 D F Yrs Dec. 5,1931 Mexico or 28a-f shov or than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🕅 No Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 United States 2616 Rigging Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Mexican White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) Architect Architecture Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item Z7 is marked oth any injury or other traumatin anneas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Celia Ramirez Miguel Marquez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2616 Rigging Drive, Annapolis, Maryland 21401 Birgitta Marquez / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 12/29/2012 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician ENAL FAILURE ACUTE +RONL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause international Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atter page 2 should be detached for i in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 🔲 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting n the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 8 LO -24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy Ren performed' Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 29c. License number 29d. Date signed (Month, Day, Year) 36581 S 12 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 Detense ERSH 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G939, 5/10/2013, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time o Physician/ Dec. 20¦13 12:30 A Hazel Moore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Spring Brook Genesis Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 38-44-8 Director 1 M 2 XF plin County, NO 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene.
27 Is marked other then "natural", or Items 23a or 28e-f show treumatic event, the Medical Examination must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 6207 2078 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: AFRICAN-AMERICAN 3 ₩ Widowed 4 □ Divorced Completed 15 Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ingustr (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) ashie ta Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Done 0 19a. Informant's Name/Belationship (Type Print), Seleta, Thornton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ige 1 end 2 sl nt of Health a t: If item 27 ls 7 10/7 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 e Department of H Importent: If ite eny Injury or ot 1 Burial 2 K Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Genetery adelphia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): Examiner Diabetes Mellitus Sequentially list conditions, if any leading to immediate cause. Enter Underlying Dun to (or as a nonsequenne of Exami attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Dementia Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year ed by the a 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown After this certificate has been sistuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 🛣 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ANursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖺 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No 2 Accident Investigation М 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title, of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067092 January 02, 2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 15245 Shady Grove Road Rockville, MD. 20850 Suite #130 Dr. Weihan Wang, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State racks Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DONALD MICHAEL Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner 05 a If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) 219-88-5820 49 Director 1 X M 2 □ F JULY 30,1963 MARYLAND 27 is marked other than "natural", or items 23a or 28a-1 ahow traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No NOTTINGHAM MD. BALTO. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 4344 HALLFIELD MANOR DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married ģ Specify: WHITE Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Completed 3 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12TH MECHANIC TAYLOR NORTH EAST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should ba fila f Haalth end Mantel H Item 27 is marked o ည DOROTHY KNOPP PAUL M. MICHAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Haalth NOTTINGHAM, MD. 21236 4344 HALLFIELD MANOR DRIVE JANE MICHAEL **SPOUSE** 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State parmit. Page 1 and Dapartment of Filmportent: If its eny injury or ottoge. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL MEMORIAL MIDDLE RIVER, MD. 1-4-2013 4 ☐ Donation 5 ☐ Other (Specify) SCHIMUNEK FUNERAL HOME INC 21. Signature of Funeral Service Lice 22 Name and Address of Facility NOTTINGHAM, MD. 21236 9705 BELAIR ROAD t 1. Enter the disease, or complicate ock or heart failure. List only one car th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires uner the use to come to the safer deeth.

Within 24 hours after deeth.

To the Funeral Director: After this cartificate has been signed by the ettending physicien end complately filled in by the funeral director, page 2 should be detached for use as the burlel-transit. Hospital or Attending Physicien: The law requires that the death cartificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Marse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certiff 29c. License number 29d. Date signed (Month, Day, Year) 12/28/2012 D15885 (00 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dec. Physician/ 30, 9:20 AM Middleman Morton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 206-14-1952 1 X M 2 □ F Nov. 12,1925 Maryland 1 and 2 should be filled within 72 hours after death with the Maryland of Health and Mantel Hyglena. Item 27 is marked other then "netural", or items 23a or 28a-f show other traumetic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Reisterstown Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21136 11990 Long Lake Dr. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Secondary (0-12) Computer Programmer Computer Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Ida Conn William Middleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reisterstown, MD 21136 11990 Long Lake Dr. Jack K. Middleman/Son or other January 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State parmit. Paga 1
Dapartmant of I
Important: If it
eny injury or o DECEMBER 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2013 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road 21. Signature of Funeral Service Licensee of Dulaney Valley. Inc. Timonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Attar this cartificata has baan signad by tha attanding physician and it funaral director, paga 2 should ba datachad for usa as tha burlai-transit Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physicien: The law raquires that the daath cartificate bar 25 hours after death.
• Funera illector: After this cartificate has been signed by the attending physicial properties that this cartificate has been signed by the attending physicial istaly filled in by the funeral director, page 2 should be detached for use as the building filled. Division of Vital Records, P.O. Box 68760 MORTON MIDDLEMAN IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🗷 Other (Specify) HOSPICE 1 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical To the Hospi within 24 hour To the Funer complataly fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 201

at v

State JACKIE JONES,
31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

32 Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

CRNP

VALLEY RD. TIMONIUM, MD 21093

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1,2586 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 29,2012 Physician/ Beverly Ruth Mulcahy 5:04 PM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Gilchrist Hospice Towson Baltimore 5. Social Security Number 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, 1938) 1938 Hours 213-36-7881 1 🗆 M 2 🖾 F 74 May Director Yrs Baltimore, Maryland permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at any any injury or. 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Director Maryland Baltimore 1XXX Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 1110 Wood Heights Ave. 21211 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 14 Bace - American Indian. 1. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 Specify:White 1 Yes 2 No 3√ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willard Leo Groomes Freda Loates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Coleman/ Daughter 5 Whitcraft Lane, Shrewsbury, Pa. 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park | January4,2013 Elkridge.Marvland 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, Inc. 21. Signature of Funeral Service Licenses 3631 Falls Road, Baltimore, Maryland 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Sequentiary its continuous, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the deeth certificate be executed sate has been signed by the attending physicien end pege 2 should be detached for use es the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No After this certificate 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural Accident 5 Pending work?
1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

0

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year) State

Medical

29a. Certifier

only one)

Signature and little of certifier

and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20071287

29c. License number

City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 2244 м Ethel A. Morgenstein 201 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Davs Hours Director 181-10-6043 1 □ M 2 🗓 F 98 Pennsylvania June 08.1914 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral Items 23a U.S.A. 20906 15115 Interlachen Drive. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. "naturel", or 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🗓 No Specify: Specify White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Elementary Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Depertment of Health end Mental I-Important: If item 27 is marked of eny Injury or other traumetic even 2008. end Mental F Is marked of ည Lilly Childs Israel Mittin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6940 Oregon Avenue, NW, Washington, DC 20015 Gwen Zuares - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Olney, Maryland Judean Memorial Grdns 01/01/2013 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Lide 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease of complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach line. Approximate Interval Between Onset and Death Immediate Cause (Final ona Physician/ AS DITATION disease or condition Medical resulting in death) Due to (or a consequence of) Examiner POXIG Sequentially list conditions, if any, leading to immediate Examiner Due to (as a consequence of): cause. Enter Underlying Cause (Disease or injury aduca that initiated events resulting in death) Last attending physicien and for use as the burial-trar Due to (or as a consequence of) Physician/Medical or Attending Physicien: The law requires thet the deeth certificate be Box 68760 f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at the control of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Division of Vital Records, P.O. JORGENSTEIN, ETHEL, 12/27/12, 2244 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24 hours efter death. 2 Funeral Director. After this certificate has been si letelv filled in by the funeral director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2= tmergency 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m Barton 8500 Old (seome 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 42588 Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 10:10 am Mattie Ella Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Village of Rockville Montgomery Rockville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Director 228-54-3771 1 □ M 2 🛚 F Yrs. 97 01/15/1915 Texas Usual Residence of Decedent 2 should be filed within 72 hours efter death with the Maryland th end Mental Hygiene.
27 is marked other then "neturel", or Items 23e or 28e-f show treumetic event, the Modest Expriner must be notified at 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 🖔 No Rockville Maryland Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 9701 Veirs Drive 20850 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Caucasian 3 ₩ Widowed 4 □ Divorced Year or Dates. 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Realtor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Ollie Mae Post Mathias Estes Department of Health end Importent: If item 27 is meny injury or other treumany injury or other treumance. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3515 Honey Locust Court, Fairfax, Virginia 22033 Martha Carr - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Kemoval from State 01/09/2013 Fairfax, Virginia 4 Denation 5 Other (Specify) Fairfax Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility Everly Funeral Home MOOLO 10565 Main Street, Fairfax, Virginia 22030 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) -ND STONE DEPENTIA Medical Examiner BNOREXIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) ettending physiclan and for use es the burlal-transIt Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 1 Yes 2 No To the Hospital or Attending Physicien: The lew requires that the dee within 24 hours after death.
To the Funcer Director: After this certificate hes been signed by the e completely filled in by the funeral director, page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Tes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 DELEMBER 21 Muchlu 1)0051158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 20850 ROCKVILLE

State Registrar UATTI AWTHOM

Box 68760

P.0.

Records.

VEIRS

Drive

970)

32. Registrat's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42589 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ATHERINE MUIR 2:37 DECEMBER AM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MEDSTAR HARBOR HOSPITAL N/A If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Min 220-76-6831 53 **Director** 1 M 2 X F 07-24-1959 Maryland Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1824 Jackson Street 21230 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 Married ģ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 N/A Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kenneth Albert Muir Sr. Catherine Estelle Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth A. Muir Jr. (Brother) 11175 Douglas Ave. Marriottsville , Maryland 21104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Glen Haven Mem. Park 12-31-2012 Glen Burnie, Maryland of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
237 E. Patapsco Avenue Baltimore, Maryland 21225 Ashley Kelley M01682 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Extensive right sided pneumonia, possibly MRSA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of, Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Box 68760 as use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 1 Yes 2 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Asthma 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b director, page 2 s autopsy performed 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this : After this e funeral c 27. Manner of Death
1 ☑ Natural
2 ☐ Accident 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28d. Describe how injury occurred 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) MD (RESIDENT) RES-001 DECEMBER 26 2812 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR U-N 02 UMBA

Registrar
DHMH 17 Rev 06-2011

State

S. HANOVER

32. Registrar's Signature

STREET, BALTIMORE, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Medical 4a. Facility, Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Tate Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 06–23–1933 Hours Min. Director 215-30-7805 1 X M 2 D F 79 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 21061 260 Hammarlee Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 K No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: 3

Widowed 4

Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) N/A Elementary/Secondary (0-12) Baltimore Sunpaper 12 Photo Engraver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Barrett Anna Raymond E. McCoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2240 Evelyn Drive Pasadena, Maryland 21122 19a. Informant's Name/Relationship (Type, Print) Cindy L. Ford (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem. Park 12-28-2012 Elkridge, Maryland 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee ,22 Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate val Between Immediate Cause (Final Physiciani CNA disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for us a consequence oi): Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events sulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II**r Qther signifi**ca**nt conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 2 AT3 2; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 24 hours after death.

Funeral Director: After this certificate helely filled in by the funeral director, page Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence & Other (Specify) Hospica ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of Mausa 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 hou To the Funel completely fi (Check only one 29b, Signature and title of dertifier 29c. License number

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who complete

JAN 0 3 2013

31. Date filed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

32,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 5:83 AM 2 Medical Facility Name (if not institution, give street a **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A 9. Birthplace (State or Foreign Sex 1 M 2 □ F 8. Date of Birth **Funeral** (Month, Day, Hours Director Maryland Aug. Usual Residence of Decedent show 10a. State 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Maryland Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 416 E. Randall Street 21230 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗓 No If Yes, Give Year or Dates. Completed 3 Divorced 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Firefighter Baltimore City Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Lauren Monaghan Nellie Smith Viola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Monaghan (Wife) Randall Street Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State any injury or c 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Brooklyn Park, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 01/04/2013 Signature of Femeral Service Licenses 22. Name and Address of Facility
McCully—Polyniak Funeral Home, P.A.
237 Fast Patapsco Avenue Baltimore, MOO-732 Maryland 21225 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause Enter Underlying Cause (Disease or linjury Due to or as a conse yience of To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician Certificate: To Be Completed by Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 🗌 Yes 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 \square Pending 1 Yes 2 Accident
3 Suicide the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nursa Practioners To the best of my 29b. Signature License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) State

Registrar

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ John Warren Miller, Jr. 2012 12 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Frederick Villa Nursing Home Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Min. Hours **Director** 1 M 2 - F 6/29/1942 214-40-8818 70 Maryland Usual Residence of Decedent 28a-f show il Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🗭 No Baltimore Owings Mills MD 10e. Street and Numbe 10a. Citizen of What Country? Funeral 21 Hiddencreek Ct. 21117 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married 1 Yes 2 No þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify.White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedem's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Westinghouse Human Resources Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o ပ John W. Miller, Sr. (nee Landry) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Karick Miller(wife) Hiddencreek Ct. Balto. MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cem 1/10/2013 Garrison Forest 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Craig Witzke Funeral Care Newburg Ave Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final disease or condition Physician/ Alherosderotic Cerebrovas cular Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence oi) for use as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) nding physician Physician/Medical death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the at 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the exithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an completely filled in by the funeral director, page 2 autopsy perform 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 28c. Injury at injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year) 12/31/12 D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

Raymora Miller

JAN 0 3 2013

31. Date filed (Month, Day, Year,

Po

Box

1525

32. Registrar's Signature

Owings Mills

MA

21117

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland , Department of Health and Mental Hygiene For State Registra Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 2012 Month Physician/ 10:03P M vicholson-Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BA Homor of SINAI Himore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 3 Director MD61 permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Health and Mentel Hyglene. Importent: If Item 27 is merked other then "neturel", or Items 23e or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at once. 10c. Pity, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 No more **WAUU** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Black, White, etc. ۵ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retire() 16b. Kind of Business/Industry (Specify only highest grade completed) Cosmetology Elementary/Secondary (0-12) ege (1-4 or 5+) osmeto 0918 lears Be 18. MOH 17. Father's Name (First, Middle, Last, ter's Name (First, Middle, Maiden Surname) bris neora Patient Dister 20a. Method of Disposition
1 ☐ Burial 2 ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory of other Baltimore remation 4 Donation 5 Other (Specify) Services 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Atherosclerutic Hearl isease Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the ettending physiclen end ched for use es the burlel-trensif Due to (or as a consequence of): Physiclan/Medical or Attending Physicien: The lew requires that the death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day 1 ☐ Yes 2 XNo 9 ☐ Unknown tor: After this certificete has been signed by the the funeral director, page 2 should be deteched 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ DISPASE RENAL STAge 1 Yes 2 No 3 Probably 4 Chknown Completed DiAbetes Meilitus 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 To the Hospital or Attending Physicien: The lew within 24 hours effer deeth.

To the Funerei Director: After this certificate hes completely filled in by the funeral director, page 2. HyperTension 1 ☐ Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical n Lacetifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0054558 2012 26 and address of person w no completed cause of death (Item 23a) (Type, Print) Itimore HOSPILA Ce INAI MEDERICK 12 31. Date filed (Month, Day, Year)
JAN 0 3 2013 32. Registrar's Signature State Registrar an

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AMEND TTEM#5perFH, G936, 2/5/2013, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 11:50 a^M Physician/ December 28,2012 Lev Nisnevitch Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery City, Town, or Location of Death Examiner Rockville Hebrew Home of Greater Washington 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday)
72 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Jan. 1, 1940 1 X M 2 - F Hours Russia Director .56. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville Maryland Montgomery 1 Tes 2 X No 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20852 6111 Montrose Road Apt#506 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: white 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Magazine Industry Photo Journalist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Rache1 Nison Nisnevitch 1 and 2 should be of Health and Me item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6111 Montrose Road, Apt#506, Rockville, Maryland20852 Tamara Nisnevitch/wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of I
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 12/29/2012 Metro Crematory, Inc. 4 Donation 5 Other (Specify) Stephanie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. ture of Fundral Service Licensee 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Dementia Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner ar Kinson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or linjury that initiated events resulting in death) Last and bunial-tran Due to (or as a consequence of): attending physician for use as the bunal Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death To the Hospital or Attending Physician; The law requires that the dewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 M No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 ☐ No Yes 21 N 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 1 within 2 To the F only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numbe 12-28-2012 mina D0064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 Rockville 20852 Fazli MD Montrose 32. Registrar's Signature 31, Date filed (Month, Day, Year) State 3 2013 JAN O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fth 2935 1-7-13 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ au 7:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ave Heights 2 108 al Security Number 12 009 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 M 2 G F Director MD 28e-f ahov permit. Pege 1 end 2 should be fliad within 72 hours efter death with the Merylend Dapartment of Heelih end Mentel Hyglene. Important: If Itam 27 is merked other then "naturel", or Itams 23e or 28e-f ahove any injury or other traumatic event, the Madical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces Š 1 Never Married 2 Married Yes 2 No Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) INSCIOR 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnai ည Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, cremator 4 ☐ Donation 5 ☐ Other (Specify) 2013 21. Signature of Funeral Service Licens 22. Name and Address of Facility march FH 240 Fredhilten Pass Bouto MD 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examin tor: After this cartificate has been signed by the ettending physicien end the funeral director, page 2 should be deteched for use as the buriel-trensit Phyalclen: Tha isw requires thet the deeth certificete ba executad Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No 25. Was case referred to cal examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 PResidence 6 Other (Specify, မူ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manny of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division deeth. 2 Accident
3 Suicide
4 Homicide М ofter deeth Director: Investigation 6 Could not be within 24 hours efter deviced to the Funeral Director completaity filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: Of the basis of examiner: To the basis of examiner: To the (Check only one) est of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) 301 St 31. Date flee (Month, Day, Year)
JAN 0 3 2013 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 29. Physician/ 4:00 pm Pearly Beulah O'Neal Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery The Village at Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 078-62-8708 Director 1 🗆 M 2 🗴 F 09/26/1924 Guyana 88 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Rockville 1 Tyes 2 No. Maryland Montgomery 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 U.S.A. 9701 Veirs Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: 3 X Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 should be flled within 72 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albertha Caroline Belgrave Clifford Nebblett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heelth an Important: If item 27 is any Injury or other trau once. 340 Greenspring Lane, Silver Spring, Maryland 20904 Cheryl Bunyan - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 01/08/2013 | Crownsville, Maryland MD Veteran's Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Sign ture of Funeral Service Licensee 6730 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shook, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Atrial FIBAllation Priysician Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying the attending physician and chec for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law hes perform 2 4No After this certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🛂 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) (Eneleep 00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHARMA 9701 Veirs 31. Date filed (Month, Day, Year)

JAN 0 3 2013 32. Registrar's Signature State Registrar

			Please Ty	y pe or Print in Blac AMEND ITEM#Ipe State of Maryland / I	ck Indelible Inl rpHYS#15perF Department of F	C. Ensure A H, G937, 37 Health and N	II Copies Ar 26/2013, WS Jental Hygien	e Legible.	
		-	For State Registrar		Certificate of L		Reg. N	7111/	42597
	Physicia		1. Decedent's Name (First, Middle, Last)	Marian Pope	PE		2. Date of Death Month December	28 Year 2012	3. Time of Death
	Medic Examin Funeral Director	er	4a. Facility Name (if not institution, give street Associated Security Number unit 6. Sex 1	neet and number) 1 S C	19 C	Location of Death		c. County of Death	Delace (State or Foreign
	>	Director	Usual Residence of Decedent 10a. State 10b. County 10c. Street and Number	rd 10c. City, Town	n or Location	City		Citizen of What Co	10d. Inside City Limits 1 Pres 2 No
	th with the ms 23a commust be	Funeral	3302 Honey	Bee Cours	4	1043		US	3 <i>A</i>
9800	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	If Yes, specify Cuba	n, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Amer Black, White Specify:	lack
	led within 72 ho Hygiene. other than "nai ent, the Medic	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	turing most of worki LRS	ing A	Kind of Business I	dustry Covernment
land	should be filed n and Mental Hy 7 is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last)	Pope		18. Mother's Nam	e (First, Middle, Maide OV	n Surname) VCD	
2	and 2 should be Health and Ment tem 27 is marked other traumatic e		19a. Informant's Name/Relationship (Type,	3	5. Mailing Address (Street a	ey Bee	, Court, a	Ellicott	Cty, MI)
Baltimore,	t. Page tment o tant: If jury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		f Disposition (Name of ry, crematory or other place Calvary)	ie) 1/2	Date 20c.	Location - City or	o, MD
Bal	permit Depar Impor any in once.		21. Signature of Fu al Service Licenses	Howells	22. Name and Address	ulford	Rel -	-wxere Tessup	MD 20194
J	hysician/ Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do rease on each line. Due to (or as a consequence)	The Carches	g, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
30 %	cate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last d.	Due to (or as a consequence					
. Box 68760	ith certifi ittending or use at	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	h 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		23d. Date of del Month	ivery Day Year
ls, P.O.	uires that the dea signed by the a Id be detached f	d by Pl	Part II. Other significant conditions control Hyper Hengie	ibuting to death but not resulting	in the underlying cause gi	ven in Part 1.			the cause of death?
Division of Vital Records,	The law require ate has been si page 2 should I	Completed by	Vascular Den	rentia			24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Vital	ysician: The la is certificate ha director, page?	To Be	25. Was case referred to medical examiner? 1 Yes 2 N No	spital: 1 ☐ Inpatient 2 ☐ ER/O	Oth	ace of Death (Chec er: 4 \(\sum \) Nursing Ho	k only one) ome 5 Residence	6 X Other (Spec	ity Assated Livin
on of	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral di	Certificate: 1	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injury 28b.	Time of 28c. Injury work	y at	28d. Describe how inj		
Division	al or Atte s after de il Directo ed in by th		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office		28f. Location (Street a City or Town, Sta		al Route Number,
	e Hospit 124 hour e Funera leted fille	Medical	(Check 2 Medical Examine)	an: To the best of my knowledge, con the basis of examination and/oractioner: To the best of my know	or investigation, in my opinio	on, death occurred a	t the time, date and pla	ce, and due to the	cause(s) and manner stated.
	To the within 2 To the comple	2	29b. Signature and title of certifier	reade no.	29c. Licens			Date signed (Month	n, Day, Year)
	3		30. Name and address of person who com	10010			olumbia 1	ND 210	91, 2012
П	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 3 201	32 Aegistrar's Signature	barre	-21			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #11 per spouse G937 3/4/13 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 7:00 PM MAM HODOL Medical County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner #102 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace **Funeral** 1 M 2 - F Days Hours Min (Month, Day, Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at Director 1 Yes 2 No Teorge Vi 10g. Citizen of What Country? 10e. Street and Number 5 10f. Zip Code 23a Funeral Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after death 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never warried 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Black 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) QR. Be 18. Mother's Name (First, Middle, Majden Sumame) 17. Father's Name (First, Middle, Last) ဂ္ ONA State, Zip Co e) 20705 Informant's Name/Relationship (Type, Pr 19b. Mailing Address (Street and Number or 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 20794 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ocardio -Prysician/ disease or condition resulting in death) Medical Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner as a consequence of transit-To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (br as a consequence of) resulting in death) Last ate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: HA NIA 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day ☐ Pregnant at time of death☐ Unknown 2 No NIA 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 N prior to completion of cause of death?

1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate has I completed filled in by the funeral director, page 2 s 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at NJA 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work?
1 Yes 2 No NJA N/A N/A Injury Investigation 6 Could not be No Accident 2 Acciden
3 Suicide 28f. Location (Street and Number or Rural Rane Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) IA N Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29d, Date signed (Month, Day, Year) ppleted cause of death (Item 23a) (Type, Print) 2415 31. Date filed (Month, Day, Year) 32. Registrar Sign State 2013 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death Month 1. Decedent's Name (First, Middle, Last) 2012 Déc

7. Age (In yrs. last birthday

10c. City, Town or Location

4b. City, Town, or Location of Death

BALHYNO'RE
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min.

9:10 PM

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

4c. County of Death

Physician /Medical Examiner

1 - For State Registrar

10a. State

5. Social Security Number

217-20-5979

Usual Residence of Decedent

Facility Name (If not institution, give street and number)

10b. County

1 ☐ M 2 💢 F

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, If a Medical once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

g physician and streets the burial-transit attending pt After this certificate has been signed by the funeral director, page 2 should be detached within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

양	MD N/A	Balt	imore			Tarres 2 100						
ire	10e. Street and Number	1	10f. Zip Code	10g. C	itizen of What Co	untry?						
Be Completed by Funeral Directo	1300 S. Ellwoo	d	21205		USA							
ner	11 Marital Status 12. Was	Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Ame							
교	1 ☐ Never Married 2 ☐ Married 1 ☐	ed Forces? Yes 2 No	n. 2	icari, etc.)	Black, White	e, etc.						
ğ	3 Widowed 4 □ Divorced If Ye a	es, Give r or Dates:	1 ☐ Yes 2 No Specify:		Specify:	ack.						
sted	15. Decedent's Education (Specify only highest grade comple		Decedent's Usual Occupation Give kind of work done during most of working		Kind of Business/	Industry						
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3e (17. Father's Name (First, Middle, Last)	•	18. Mother's Name	(First, Middle, Maide	n Surname)	,						
2	Kolward Koberts	son	Laura	- Wats	on							
	19a. Informant's Name/Relationship (Type. Prin	t) 19b. I	Mailing Address (Street and Number or Rural	Route Number, City	or Town, State, 2	Zip Code)						
	Yvonne Smith-	Daughter 50	166 2nd St. N.W. Wa	shinaton, .	D. C. 20	011						
	20a. Method of Disposition	cometery	Disposition (Name of Da crematory or other place)		Location - City or	Town, State						
	1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State Garri	1 1/1/	2013 100	Jinac Mi	11s. MD						
	21. Signature of Funeral Service Licensee	DIOI VI	22. Name and Address of Facility	anch Elit.	EAST							
	* (X YMI) TO		IINI E NAVEL AVE	2. 12/1LA	,HD2	1202						
	23a. Part1. Enter the disease, or complications	that caused the death. Do no	ot enter the mode of dying, such as cardiac or		1)10	Approximate						
	shock, or heart failure. List only one cause Immediate Cause (Final	e on each line.	11 1 6 1			Interval Between Onset and Death						
	disease or condition resulting in death)	Congesti	e teart tulure	2								
	Di	ue to (or as a co se quence of): 4554			3 years						
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ian	in the past 12 months?	es, outcome of pregnancy Live birth 2 Fetal death	3 Ectopic pregnancy	- 10	23d. Date of de Month	Day Year						
Completed by Physician/Medical Examiner		l Pregnant at time of death l Unknown	5 Other (specify)									
Ph	Part II. Other significant conditions contributing	g to death but not resulting in t	the underlying cause given in Part I	23e. Did tobacc	use contribute to	the cause of death?						
b	Shave	gg			1	robably 4 🗌 Unknown						
sted												
ple				24a. Was an autopsy	24b. Were at prior to	utopsy findings available completion of cause of						
ő				performed?		2 □No						
Be (25. Was case referred to medical examiner?		26. Place of Death	(Check only one)								
.0	1 Yes 2 No Hospital:	1 ☐ Inpatient 2 ☐ ER/Outp	oatient 3 DOA Other: 4 Nursing Hom	ne 5 🗆 Residence	6 ☐ Other (Spe	ecify)						
Ë		Date of Injury 28b. Ti (Month, Day, Year) Inj	me of 28c. Injury at 2 ury Work?	8d. Describe how in	jury occurred							
atic	2 Accident investigation		M 1 □Yes 2 □No									
titic	3 ☐ Suicide 6 ☐ Could not be determined 28e.	Place of Injury - At home, farr building, etc. (Specify)	n, street, factory, office	8f. Location (Street City or Town, Sta	and Number or R	ural Route Number,						
Cer					, <u> </u>							
Medical Certification: T			death occurred at the time, date and place, a									
edi	one) and	d manner stated.	The street of th	at the time, date t	and place, and da							
Σ	29b. Signature and title of certifier	. ^ . ^	29c. License number	29d. [Date signed (Mon	th, Day, Year)						
	* Tarent Vin	naletoull	0 00061677	1.	2/27/	12						
	30. Name and address of person who completed	d cause of death (Item 23a) (1	ype, Print)									
	KAREN DONALDSON	9715 HOI	of Hway Drive T	Berlin, n	11) 21	811						
te		32. Registra's Signature	1			<u>-</u>						
ar ,	JANUS 2013 Censu	a jo. jajano										

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Health & Rehabilitation Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-30-4475 **Director** 1 □ M 2 🏋 F 78 Apr. 29, 1934 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show winjury or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 United States 606 Lorca Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Spring Grove Hospital Nurse Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Louis Edward Ettie Furgerson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah O'Doherty / Daughter S. Prospect Avenue, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 12/31/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DWTH Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the all ending physician end completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 D Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural
2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my existing death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Pay, Year) scenta

State Registrar

DHMH 17 Rev 06-2011

445 Depense Highway

MD 2140

cause of death (Item 23a) (Type, Rrint)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#20b, perffl, G935,1/3/2013, WS
State of Mary land Department of Heavy land Departmen 42601 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death De Combe Physician/ 20 22, ZO M Grace Irene Ghee Phillips Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Baltimore Levindale Hebrew Ger. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Pay, 05/19 Days Hours Min 1 □ M 2 💢 F 214-24-9927 92 Lunenburg 1920 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at the Maryland Director N/AMD Baltimore 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21216 Funeral with 3506 Fairview Ave. filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes Yes Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Black Specify: 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Admin. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 7 in and Mental Hygiene. 7 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Clerk 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Cornelia Rainey permit. Page 1 and 2 should be fi Department of Heath and Menta Important; If item 27 is marked any injury or other traumatic ev once. မ Crawley Ghee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) UNK 3506 Fairview Ave. Baltimore, MD 21216 Annie R. Phillips 12/29/2012 20b. Place of Disposition (Name of New Party Bapters) st 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Kenbridge, VA Church Cemetery 4 ☐ Donation 5 ☐ Other (Specify) ²²Joseph H. Brown, Jr. Funeral F 2140 N. Fulton Ave. Baltimore, 21. Signatur Funeral Home PA of Funer I Service Licent Þ 21217 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Odv mle -Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) use as the burial-trans that initiated events resulting in death) Last been signed by the attending physician and Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has completed filled in by the funeral director, page 2 s autopsy performed 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Q evindale 32. Registraris Signatu State Registrar

6 mce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Fer FH C935 1/03/2013 JH State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 2012 9:19 a M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Balto. Wash. Med. Center Glen Burnie If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 6 Sex 8 Date of Birth **Funeral** Days Min (Month, Day, Year) 217-24-0342 Director 1 □ M 2 🔀 F 83 Yrs. 05/13/1929 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Southbridge Apt.B 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 9th College (1-4 or 5+) Domestic Engineer Private Homes Be 18. Mether Name (First, Middle, Maiden Sumame)
<u>Eleanor</u> Miller 17. Father's Name (First, Middle, Last) 2 William Pearmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Queen (Dghtr.) 7866 Dero Drive Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Hall U.M.C. Cem. 1/5/13 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Joseph H. Brown, Jr. Funeral Home PA wan. 2140 N. Fulton Ave. Baltimore, MD21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examir or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 N Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed? 1 Yes 2 Ho To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Burse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Burse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 □ 29b. Signature and title ertifie 29d. Date signed (Month, Day, Year) 9 M And the cause of death (Item 23a) (Type, Print)

7 7575 RITCHIE HICHWAY GLEN BURNE Warricos & 2106 SHEDHON 9 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 3 JAN 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42603 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2 5:30 PM PRESTON Day GERTRUDE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE MD If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) Days 214 30 525 Director 1 □ M 2 🗙 F June 14, 1933 PA Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health end Mentel Hygiene.
ent: If Item 27 is merked other than "naturel", or Items 23e or 28e-f show ury or other traumetic event, the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director GLen Burnie MD Anne Arundel 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 607 Greenway Rd SE 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes XXX No If Yes, Give Baltimore, Maryland 2/1215-0036 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced WHite Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Stewardess Pan Am Airlines Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alvin Preston Matilda Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Taylor Daughter 607 Greenway Rd SE, GLen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 e Department of H Importent: If Ite eny Injury or ot Date 1 Burial 2 Scremation 3 Removal from State 4 Dopation 5 Other (Specify) Dec 28, 2012 Baltimore, MD 22. Name and Address of Facility
Fink Funeral Home, P.A. un of Fujarral Sayura License Gregory Fini M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospitel or Attending Physician: The law requires thet the death certificete be executed erel Director: After this certificate hes been signed by the ettending physician end filled in by the funeral director, page 2 should be detached for use es the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospitel or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2. autopsy 2 🗆 No Yes 2 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical 8 8 26. Place of Death (Check only one) Certificate: To I 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
injury 28c 4 Nursing Home 5 Residence 6 Other (Specify) PRESTON 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21229 CATON 900 STAGNES AVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pace, Jr. Richard Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner COMICO Lenta 9. Birthplace (State or Foreign if Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) Date of Birth al Security Numb **Funeral** Days (Month, Day, Year) Director 413-70-0148 1 X M 2 □ F 68 July 23, 1944 Tennessee Usual Residence of Decede 27 is merked other then "neturel", or items 23e or 28e-f show traumatic event, the Medical Evarians must be notified at 10d. Inside City Limits Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ent: If item 27 is merked other then "neturel", or items 23e or 28e-f shov 10b. County 10c. City, Town or Location Director 1 Yes 2 No Reisterstown Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21136 84 Shetland Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black White etc. 1 X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Rental Car Driver 08 n/a Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٥ Hollomon Richard Pace, Sr. Dorothy John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 84 Shetland Circle, Reisterstown, MD JoAnn Pace/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State permit, Page Depertment of Importent: If eny injury or once. Forest Hill East Cem. 12/29/2012 Memphis, TN 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc
10 W. Padonia Road, Timonium, Maryland 2 21093 Bryah W. Clary 23a. Part I. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Cause (Final Due to (Irlas a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): ettending physician and for use es the burlal-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate hes been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 1No 1 Inpatient 2 PER/Outpatient 3 I DOA Certificate: To After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Natural 5 Pending after death.

Director: Af
d in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f Location (Street and Number or Rural Route Number

Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours a within 24 hou To the Fune completely fi

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Whying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on **%**ignati 29d. Date signed (Month, Day, Year) 12

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

erson who completed cayse of death (Item 23a) (Type, Print)

0 31. Date fil Registrar's Signature

State Registrar

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Irene V. Pitcher December 27, Physician/ Day 2012 12:05 P M Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 3133 Dudlev Avenue Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 213-20-8919 **Director** 1 🗆 M 2 🗶 88 MD Sept 28, 1924 Usual Residence of De 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** be notified 1XX Yes 2 No MD N/A Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21213 3133 Dudley Avenue items 12. Was Decedent Ever in U.S. Armed Forces?

1 XXYes 2 \sum No If Yes, Give 60-63 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XXNever Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 Year or Dates. 60–63 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the +2 State of MD Mail Room Supervisor Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alma Valdivia Leslie Pitcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Nora Dudman (Niece) 3133 Dudley Avenue Balto, MD 21213 20a. Method of Disposition

XX Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans' Cemetery 20c. Location - City or Town, State 1/09/13 Garrison Forest, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. Signature of Funeral Service Licer 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or convolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, flaty, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Que to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas page 2 autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🛣 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending iniury Accident Investigation after death Director: A d in by the f Suicide 6 🗌 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Dir

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

31. Date filed (Mohth, Day, Year) State Registrar

only one 29b. Signat

Name and add

of person who completed cause of death (Item 23a) (Type, Print)
Tolvin Johns Hopkins Bayview Medical Center, Balkimore, Maryland

00032548

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 28,2012 0528 ROSE F. PONDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) 88 Director 217-18-5961 1 M 2 X F MAY 7,1924 MARYLAND Usual Residence of Decedent 28a-f shov 10d. Inside City Limits Oa. State 10c. City, Town or Location Funeral Director MD. HARFORD **STREET** 1 🗌 Yes 2 😿 No or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ms 23a c must be USA 812 CHANCE STREET 21154 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2X No Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mentar rigging is marked other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Health and Mental Hygiene. FOOD SERVICE MANAGER 11TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SERAFINA DELL'ACQUA ORAZIO FARO <u>dot</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important, If item 27 is any injury or other trau 812 CHANCE COURT STREET, MD, 21154 DTR. DEBORAH MANCE 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date C1/86/400(1 XBurial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 1-3-2013 PARKVILLE, MD. Donation 5 Other (Specify) 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR 21. Signature of Funeral Service Licensee BEL AIR, MD. 21014 610 W. MACPHAIL ROAD 23a. Part 1. Stor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death 1) NONHOWA Physician/ disease or condition Medical resulting in death) Examiner PONDER M300 37119 Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trai resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending phys I for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 Yes 2 No Month Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Wo 24a. Was an autopsy performed? Yes 2 No has page 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ဂ္ 1 🗌 Yes MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a, Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation after death Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours To the Funeral I completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractificates. To the best of my 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

De NUSHA SIGNAL DRIVE,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mont PΜ Verla Price December 4:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8506 David Avenue Parkville Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 90 Director 213-16-5395 1 □ M 2XX January 28,1922 Maryland 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It health and Mental Hygiene item 27 is marked other then "netural", or items 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Parkville 1 Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8506 David Avenue 21234 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify If Yes, Give Specify: White Completed XX Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Rayman Daisy Kolbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Importent: If item 27 eny injury or other tr 8013 Yellowstone Road, Kingsville, MD 21087 Milton C. Price, Jr. - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Page 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cemetery Dec. 29, 2012 Baltimore, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Charlel and Cremation Services - Parkville 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ meomonia disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy hours after death.

nerel Director: After this certificate by filled in by the funeral director, pag 1 Yes 2 No Yes **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death

1 Avatural

2 Accident

3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completely fi 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number DOUS 19260 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bathmas 37 PPE 203 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 42608 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December ^{Day}9 Physician/ 9:10 ам 2 0 T 2 George R. Price Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 055-36-2185 1 M 2 □ F Director 69 10/26/1943 New York parmit. Paga 1 and 2 should ba filad within 72 hours aftar daath with the Manyland Department of Haalth and Mantal Hygiana. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Montgomery Maryland 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? U.S.A. Funeral 20906 1408 Casino Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 14. Race - American Indian. 11. Marital Status African-American Specify: þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Private Business Developer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis B. Price Rubu Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1408 Casino Circle, Silver Spring, Maryland 20906 Antoinette Price - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lincoln Crematory 01/04/2013 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hoapital or Attanding Physician: Tha law requiras that tha daath cartificata ba axecuted within 24 hours aftar daath.

To the Funeral Director: Aftar this cartificata has baan signad by tha attanding physician and complataly fillad in by the funeral director, paga 2 should ba datached for usa as the burial-tranalt Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available που αυτορεγ findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of injury 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1821+000 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 32. Registrar's Signature

shaheen

31. Date filed (Month, Day, Year)

JAN 0 3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Doris Teath Paster December 27, 7:34 aM 2012 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 09/04/1919 Birthplace (State or Foreign Country) 1□M 21XF Days Hours 038-07-5858 93 Rhode Island Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 TYes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6105 Montrose Road, Room 4200B 20852 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 X Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Clerk U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Tcath Lillian Schein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Hankin Street, Silver Spring, Maryland 20910 Mark Paster - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Beth Tfiloh Cemetery 12/30/2012 Woodlawn, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 2 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of); Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of): IF FEMALE If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4□Pregnant at time of death Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2MNo 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed burial-transi Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Examiner Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Baltimore, Maryland 21215-0036

þ

Medical

29a. Certifier (Check only

Physician/Medical Completed Be

State Registrar 29b. Signature and title of certifier

29c. License number DOC648

Rockville

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rd

29d. Date signed (Month, Day, Year)

12-27-2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fazli, MD @121 Montrese

31. Date filed (Month, Day, Year)

JAN 0 3 2013 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	E-m		- 1		-4	-	U	- 6	~

Usual Residence of Decedent 10c. City, Town or Location Waryland Anne Arundel Millersville	3. Time of Death 1020 hrs
### Funeral Director Funeral	I 1020 nrs I
8442 Main Avenue Riviera Beach Anne Arundel Riviera Beach Anne Arundel 102 Security Number 219-25-4323 1	
Social Security Number 6. Sex 7. Age (In yrs. last birthday) Social Security Number 6. Sex 27. Age (In yrs. last birthday) If Under 1 Year If Under 24-Irs. 8. Date of Birth(MMDD/YYYY) 6-Birch 1 10s. State 1 10s. Curty 1 10s. List mile 1 10s. State 1 10s. Curty 1 10s. City. Town or Location 1 10s. State 1 10s. State 1 10s. Curty 1 10s. State 1 10s. State 1 10s. Curty 1 10s. State 1 10s. Curty 1 10s. State 1 10s. S	
Director Director	
10a. State 10b. County 10c. City, Town or Location Millersville 10f. Zip Code 10g. Citizen of What County 10d. Zip Code 10d. Z	^{ountry)} Maryland
Maryland Anne Arundel Millersville	10d Inside City Limits
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1 1 1 1 1 1 1 1 1 1	ntry?
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	in a taring Diggi
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	ncan indian, black,
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Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	Company
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Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	e, Zip Code)
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	and 21108
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	Town, State
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	aryland
Physician 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Combined Methadone and Alprazolam Intoxication Due to (or as a consequence of): b	g.
Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	Approximate Interval Between Onset and
or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	Death
Cause. Enter Underlying Cause C	
Unbease of lightly trial initiated events resulting in death) Last events resulting in death events resulting resulting resulting in death events resulting resu	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): AMENDED 23a, 27, 28a-f, per me, g935 1-23-13 sm IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	1
9 F FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver	·
23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month	Day Year
23b. Was decedent pregnant in the past 12 months? 1	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	
1 Yes 2 ✓ No 3 Pro	
Sp. 10 de man de	utopsy findings available completion of cause of
The law requires a figure has been significant has	'es 2 No
25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other	or: Coopp
Nursing Home 5 Residence 6 ✔ Other 1 ✔ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	ar. Scarie
Compared to the state of the st	
Accident Investigation 22 Accident	ural Route Number, City
Second State Seco	I Avc.
	nted. he cause(s)
Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as see (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the control of the cause (s) and the cause (s)	
O.C.M.E. December 29, 2	
30. Name and address of person who completed cause of death (Item 23a)	onth, Day, Year)
Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	onth, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar	onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death PINSKY DECEMBER Physician/ 5:22 LOUIS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALMMORE HOSPINAL NORTHWEST If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Director 216-42-0603 1 X M 2 □ F 67 06/07/1945 MD or then "neture!", or Iteme 23e or 28e-f show the Medicel Examirer must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Meryland **Funeral Director** 1 Yes 2 N No BALTIMORE OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? USA 21117 3410 ASSOCIATED WAY, APT. 107 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tel Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BAIL BONDS Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Heelth end Mentel File of Heelth end Mentel Filtem 27 is merked of ပ **GERSON** BERNARD PINSKY KATIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 MAPLE RIDGE ROAD, REISTERSTOWN, MD 21136 BRIAN PINSKY/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 e
Depertment of H
Importent: If ite
eny injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 01/02/2013 WOODLAWN, MD BETH TFILOH CONG. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Sicense 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition CHRONIC OBSTRUCTIVE DISEASE Pnysician/ PULMONAMY Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sicien end burlel-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificete has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be detached for use es the burlel-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown BLADDER 24b. Were autopsy findings available prior to completion of cause of YM PHOMA 24a Was an autopsy
performed?

1 Ves 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ည 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: Je the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Pr ctifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of cert D0060293 DECEMBER 30,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

OLD COURT

RD

5401

32. Registrar's Signature

M.D

AHMED

MURINIZA

31. Date filed (Month, Day, Year) JAN 0 3 2013 PARSAUSTONN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42612 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2012^{ar} 26° 9:30 AM Ouinn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare Anne Arundel Brooklyn Park If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year))5–17–1922 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 215-12-9020 Country Director 90 1 M 2 X F Maryland Usual Residence of Decedent or 28a-f shov if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21230 1709 Light Street permit. Page 1 and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other then "natural", or items: empiny or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Own Home N/A Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Martin J. Quinn Mary Miencke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Ouinn (Brother) 9201 Snyder Lane Perry Hall, Maryland 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Schwartz Cemetery 12-29-2012 Baltimore, Maryland 21. Signature of Funeral Service Licensee Ashley Kelley 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 130 Fast Fort Avenue Baltimore, Maryland 21230 WENNER M01682 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 3day neumouca Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injuly that initiated events Certificate: To Be Completed by Physician/Medical Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft din by the fur Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 130555 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7956 31. Date filed (Month, Day, Year) Deckwood MA

DHMH 17 Rev 06-2011

State Registrar

32. Registrar's Signature

			Pleas ame	se Type or Print in End 1 tem 5 per f State of Maryland	Black h g	k Indelible Ink 935 1–24–13 epartment of F	k. Ensure A vt lealth and N	All Copie: Mental Hy	s Are	e Legible.	42613
	1983	_	State Registrar			Certificate of D			Reg. No	G. 0 1 A.	72010
	Physicia	n/	1. Decedent's Name (First, Middle, I	Elizabeth		Ruppin		2. Date of De	ath Da	28 2015	3. Time of Death 9:06 P M
	Medic Examin		4a. Facility Name (if not institution, g			4b. City, Town, or	Location of Death	Decemb		28 2015 :. County of Deat	
	<i>)</i>			aris Hospic			7001 UI				more
	Funeral Director		5.36 Security Number 38.9759 Usual Residence of Decedent	7. Age (In yrs. lat	31 Y	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)		thplace (State or Foreign untry)
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ctor	10a. State 10b. County	10c. City,	, Town o	or Location					10d. Inside City Limits 1
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Number		<u>u</u>	10f. Zip Code		Т	10g. C	itizen of What Co	
	h with ns 23a nust b	nera	3704 Mari	mon Hue			207			us	A
. (0	or iten	by Fu	11. Marital Status 1 ☐ Never Married 2 ☑ Marrie	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No		13. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
p. □	ural", ural",		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 ☑ No	Specify:			Specify: B	lack
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L2 and	be filed ental Hy ked oth Ic event	To Be	17. Father's Name (First, Middle, Las	la llace			18. Mother's Nan	ne (First, Middle,			
, 2012 Maryland	should be fil and Mental is marked raumatic ev		19a. Informant's Name/Relationship	P (Type, Print)	19b.	Mailing Address (Street a	and Number or Rui	al Route Numbe		r Town, State, Zij	o Code)
	and 2 sh Health a em 27 is ther tra		Wilbert L	Ruffin	3	704 Mai	mon A	Tue, E	<u> 3a</u>	Himore	4 MD 21267
. =	Page 1 a nent of H ant: If ite ury or ott		20a. Method of Disposition 1 Burial 2 Cremation 3	3 ☐ Removal from State	lace of [emetery,	Disposition (Name of crematory or other place	(e)	Date	20c. l	Location - City or	Town, State
MBH altin	permit. Page 1 Department of Important: If i any Injury or c ance.		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Lig		//9	Menioral 22. Name and Addres	ss of Facility	51201B)	FUME	100, Me
DECEMBER Baltimo	E E E		Man K	- Joulell &	4-	4600 Li	berty	Height	石	Ave, B	alto MD
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	Physician/ Medical		disease or condition resulting in death)	a. CEREBROVASO Due to (or as a conseque							
	Examiner	je l	Sequentially list conditions,	b. —		ı.					
M	rted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence or,	j:				0	
20	executed ian and urial-transit	_	that initiated events resulting in death) Last	Due to (or as a consequent	ence of):					
68760	death certificate be ne attending physici ed for use as the bu	edic		d							
.89	certific ending use as	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal	ncy	3 🗆 Ectopic pregnanc	21/			23d. Date of de	livery
FFI Boy	death the atte	ysici	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 Pregnant at time of do		5 Other (specify)				Month	Day Year
MAMIE RUFFIN sords, P.O. Box	I law requires that the death certificate be ex has been signed by the attending physician ge 2 should be detached for use as the buria	Completed by Physician/Medica		ns contributing to death but not resu	ulting in	the underlying cause give	ven in Part I.	23e. Did t	obacco	use contribute to	the cause of death?
	quires en sigr ould be	ted b						1 🗆	Yes 2	No 3□P	robably 4 🗆 Unknown
MA	law re has be ge 2 sh	mple						24a. Was auto		24b. Were au prior to death?	topsy findings available completion of cause of
<u>~</u>	an: The tificate tor, paç		25. Was case referred to medical	1		26. Pl	lace of Death (Chec	1 ☐ Yes	2 X N	lo 1 ☐ Ye	s 2 🗆 No
Vita	hysicia his cer al direc	မ	examiner? 1 ☐ Yes 2 👿 No	Hospital: 1 ☐ Inpatient 2 ☐ I		patient 3 DOA Othe			dence	6 X Other (Spec	city) HOSPICE
n o	ding P th. Affert funera	cate:	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investiga	(Month, Day, Year)	28b. Tir inj	ury work	yat ⟨? Yes 2. □ No	28d. Describe	how inju	ry occurred	
MAMIE Division of Vital Records,	r Atten er dea rectors	Certificate:	3 Suicide 6 Could no	ot be				28f. Location (iral Route Number,
Ö	pital ours a eral Di		29a. Certifier 1 Certifying F	Physician: To the best of my knowle		eath accurred at the time	e date and place				totod
	To the Hospital or Attending Physician: The la within 24 hours ar er death. To the Funeral Director: Affer this certificate ha completely filled in by the funeral director, page	Medical	(Check 2 Medical Ex	taminer: On the basis of examination Nurse Practitioner: To the best of m	and/or	investigation, in my opinio	on, death occurred a	at the time, date	and plac	e, and due to the	cause(s) and manner stated.
	with to t		29b. Signature and title of certifier	es an		29c. License	e number		29d. D	ate signed (Mant	h, Day, Year)
	3		30. Name and address of person wi	7- 0 1111	23a) (Ty	/pe, Print)	77 172	-	/	431/6	14
			JACKIE JONES,	CRNP 2300 DULA	ANEY	VALLEY RD.	TIMONI	UM, MD	2109	3	
	Sta Registra		31. Date filed (Manth Day Year) 20	013 S2. Registrar's Signation	ure	ares					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) (2. Date of Death Month I Physician/ 2 416 Medical Eacility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl Examiner 8. Date of Birth (Month, Day, 2710 Work Birthplace (State or Foreig Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Hours 00 1 X M 2 □ F Director Maryland f show 10b. County 10c. City, Town or Location 10d. Inside City Limits aţ Director notified Maryland Baltimore 28a-f 1X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? þe 23a Funeral with 21207 3005 Granada Avenue **Examiner must** USA or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify:Black "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Department of the ath and Mental Hygene Important: If item 27 is marked other the any injury or other traumatic events. Hygiene. Baltimore City the Police Officer 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Ringgold Mable Batty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3005 Granada Ave.Baltimore, Maryland 21207 Eleanor Ringgold/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 01/07/13 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityChatman-Harris Funeral 5240 Reisterstown Rd.Baltimore, MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Po in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No Unknown g Unknown P.O. Part II. Qther significant conditions contributing o death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 4 Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform 1 Yes 1 Yes 2 No or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 1 Inpatient 2

28a. Date of injury
(Month, Day, Year) ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of De 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 🗌 Yes 2 🗌 No hours after death ineral Director: A by the Investigation 6 Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 hou.. the Funeral Dire... 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Ocertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

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completely fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on of certifie 29b. Signatu 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

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2013

32. Registrar's Signature

2000 West RA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42615 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date C Month 28 3. Time of Death 2012 Physician/ 2035 Ruth P. Rutherford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4018 Wilsby Ave Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 1927 SC Director 237-36-7918 Usual Residence of Deceder 1 M 2 V 85 March 12, 10d. Inside City Limits 10b. County 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a, State Director 1 Yes 2 No N/AMaryland Baltimore 10g. Citizen of What Country? 10e. Street and Number Funeral USA 4018 Wilsby Avenue 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 Yes 2 No δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Physical Therapist Stella Maris 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Nathan Thomas Lois Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4913 Gunther Ave.Baltimore, Maryland 21206 f Health a item 27 i other tra Peggy Little/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 Department of I Important: If its any injury or of once. 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home allere 5240 Reisterstown Road Baltimore, MD 21215 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequency of): Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 ☐ Yes 2 🗷 No 1 Yes 2 N within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. he cause(s) and man.... 29d. Date signed (Month, Dat, Year) only one 29c. License number, 29b. Signature and title of certifier 306 30. Name and address of person who completed cause of death (Item 23a) (Type) Print) X0 € 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 3 2013 Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1ce 1:45 AM December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAL HOSPITAL OF BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 149-09-9296 (Month, Day Hours Country) Director 1 M 2 DF Usual Residence of Decedent th end Mentel Hygiene. 27 is marked other then "neturel", or Items 23e or 28e-f show treumetic event, the Medical Examinar must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Ballimore 1 ☐ Yes 2 ☐ No MA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funerai 3800 W. Kodgers of 2121. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ğ Black, White, etc. 1 Newer Married 2 Married filed within 72 hours efter 1 Yes 2 No Specify: Specify: BLack 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT, use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4 or 5+) osewood State Hospita NURSE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Page 1 end 2 should be aine obinson Punstal 19a. Informant's Name/Relationship (Type, Print) 515+eR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/20 7 KNOWN Bolto. Md. Health tem 27 MAIR an 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State permit, Page Depertment of Importent: if eny injury or once. 26 4 Dopption 5 Other (Specify) et Co ARyland V PAHENT 21. Signature of Funeral Service Lipensee Cha 21213 23 art 1. Enter the Jis shock, or heart failu turmediate Cause (Final disease or condition resulting in death) , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between List only one cause on each line Physician/ PNEUMONIA Medical Due to (or as a consequence of): Examiner CONGESTIVE HEART FAILURE >10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): Hospital or Attending Physicien: The lew requires that the deeth certificete be executed Cause (Disease or injury Director: After this certificate has been signed by the ettending physicien end d in by the funeral director, page 2 should be detached for use as the burlel-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 $^{<}$ Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month 4 Pregnant at time of death Day 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC KIDNEY DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No. 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending death. ☐ Accident Investigation 3 Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a
To the Funerel C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 28 K RES -000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MADI NAGENDRA 51 INAS

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State

Registrar

31. Date filed (Month, Day, Year)

0 3 2013

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death D97 Physician/ December 2012 7:10 AM Muriel Louise Dotson Rigby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Baltimore University of Maryland Medical Ctr Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Davs (Month, Day, Year) Director 1 🗆 M 2 👿 F unk October 30, 1943 Ohio 69 Usual Re er then "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 XYes 2 No Baltimore Maryland Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21215 United States 2613 Springhill Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: **Black** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Kingdom Hall I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Jehovahs Witnesses Pioneer it. Page 1 and 2 should be filed wit rtment of Health and Mental Hygie rtent: If item 27 is marked other njury or other traumatic event, III Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မှ Betty Dotson Australia Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reese Yospe (Daughter) 7424 Whitaker Avenue, Lake Balboa, California 91406 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Importent: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 12/27/2012 Catonsville, Maryland 21. Signature of Funeral Service Licensee Stephanie G. Ouster 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Spontaneous, non-traumatic subdural hematoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The lew requires thet the death certificete be executed bunel-trensi and Due to (or as a consequence of): the attending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy łó in the past 12 months? Day 5 Other (specify) 1 Yes 2 No the funeral director, page 2 should be deteched 9 Unkлown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ģ 1 Yes 2 TNo 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has To the Hospital or Attending Physician: The within 24 hours after death.
To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🖫 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

Registrar

court

30. Name and address of person

31. Date filed (Month, Day, Year)

Andreas , MD

JAN 0 3 201

MD

impleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

727323

South Green Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0:20 AM Geraldine M. Roesler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner osedale Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral (Month, Dav. Year) Months Hours 219-28-7963 80 Director 1 M 2 XF Oct. 1, 1932 Maryland item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Medical Everniner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location Director Parkville Baltimore 1 Yes 2XXNo Maryland 10g. Citizen of What Country?
United States 10e Street and Number 10f. Zip Code Funeral 8543 21234 Kings Ridge Road America 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. ۾ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "na any hiury or other traumatic event, the Medagonce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Henry Wilfer Catherine Hock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Roesler - Son 1204 Bancroft Court, Belair, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus Cem Jan 5,2013 Dundalk, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Evans Funeral Chapel and Cremation Services 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed?/ Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of de MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q 40 be 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rudasill 3:00 Melvin Η. 2012 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford County 4024 Abingin Drive Abingdon 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral July 10, Year) Months Days Hours Min. Director 212-34-3116 1 **x** M 2 □ F 76Yrs Balt. Maryland 1936 Usual Residence of Decedent or then "netural", or items 23e or 28e-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. d other then "netural", or items 23e or 28e-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Abingdon Maryland Harford 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code Og. Citizen of What Country? United States of America Funeral 21009 4024 Abingin Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married timore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: white Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Truck Driver 12 permit. Page 1 end 2 should be filed w Department of Health and Mental Hyg Importent: If item 27 is marked othe eny injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ρ Ruth Selby Harry Rudasill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 4024 Abingin Drive Abingdon, Maryland 21009 Mrs. Loyar B. Rudasill/ wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State December 28, 1 Durial 2 Cremation 3 Removal from State Evans Funeral Chapel 2012 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequenun h Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a nonsequence of): Exami ttending physician and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day ed by the detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pege 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes 2 X N 24 hours efter death.

Funeral Director: After this certifica etely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💢 No Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospitel Medical Provision: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check within 2 only one) and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, cause of death (Item 23a) (Type, Print 30. Name and address of person who completed MI State

Registrar

12-09907 Melissa Santiago Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 42620

	1- For State Registrar			C	ertificat	e of	Death					Reg. No).			
Physician/		Name (First, Midd	le,Last)							2	2. Date of D	eath			3. Time of De	eath
Medical Examiner	Melis	sa Sant	iago								Month Decemb	er 26,	2012 Yea	' I	1748 hr	S
	_	me (if not institution	on, give street and	number)		4b. City, Town, or Location of Death Baltimore					•••	4	c. County o	f Death		
Funeral Director	5. Social Secu 210-6	rity Number 2 – 3 9 4 4	6. Sex	7. Age (in yr.	s. last birthd							3irth(MM/DD/YYYYY) 9. Birthplace (State or Foreign PA Country)			or	
	Usual Residen	ice of Decedent								1				1		
à	10a. State	10b. County		10c. C	ity, Town or	Locatio	on .								10d. Inside C	City Limits
р мож	PA.	York	ς.	Yo	rk										1 X Yes	2 No
Maryland 28a-f show any d at once. ector	10e. Street and	d Number					10f. Zip C	ode				10g. Ci	tizen of Wh	at Count	ry?	
h the Maryland 3a or 28a-f sh lotified at onc			ne Stre	et			174					US				
h wit	11. Marital Sta			ecedent Ever in Forces?	U.S. 1		Decedent s, specify (cify Yes or l	No-	lo- 14. Race - American Indian, Black, White, etc.			lack,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other tranmatite event, the Medical Examiner must be audified at once. To Be Completed by Funeral Director			arried 1 Yes	2 X No	>						rto F	≀ica			ite	
sturs (15. Decedent		cify only highest g	ade completed) 16a. De		s Usual Od					16b.	Kind of Bu	siness/In	dustry	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Stokes Physician/ Month Day 2012 December 6:59 DM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Northwest Hospita Kanallstown If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 212-26-5328 Director 1 M 2X F 08/28/1931 Maryland Usual Residence of Decedent or then "netural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Gwynn OAk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7125 Campfield Road 21207 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ঠ Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black Completed 3 Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business/IndustryAdmin. 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Social Security 12th grade Lead Claims other treumetic event, Be permit. Page 1 and 2 should be file.
Depertment of Health end Mental HImportant: If item 27 is meany injury or othe-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John D.Wilson Lynette Holloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Stokes-Kent/Daughter 1635 Ramblewood Rd.Baltimore, Maryland 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 01/02712 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State Arbutus Maryland Arbutus Memorial Park 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home lle 4210 Belair Road Baltimore, Maryland 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events es e consequence of sicien and burial-transit Due to (or as a consequence of) resulting in death) Last ites abnormalities ed by the attending physicien deteched for use as the buria Physician/Medical To the Hospital or Attending Physician: The lew requires thet the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be deteched for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 X No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မှ 1 Nation 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 📈 Natural injury 5 Pending ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as 🗍 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 242810 Gramatikova MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ancla Gramati Rova 5401 Old Court Road, Ranalistown, Maryland 21133

State Registrar 31. Date filed (Month, Day, Year)
JAN 0 3 2013

32. Regis ar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month December 5241 M 2012 Medical Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore petal ot 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 218-12-8009 1 **M** M 2 □ F Director 86 10/1926 23e or 28e-f show t of Health end Mental Hygiene. If item 27 is marked other than "natural", or Items 23e or 28e-f sho or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore 1 Myes 2 □ No 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21216 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during the DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be မ listown, YMD 21133 20a. Method of Disposition

1 Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pege 1 a
Department of H
Important: If its
eny injury or ot cemetery, crematory or other p rownsville 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Funeral Services 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): physician and s the buriat-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical 68760 ettending p IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of cleath 5 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month Pregnant at time of death Day 5 Other (specify) 1 Yes 2 No ed by the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sinal director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one examiner? ည 1 🗌 Yes 2 TLH6 Other: 1 Inpatient 2 FR/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Medical Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 1 Natural 2 Accident 5 Pending death, 1 ☐ Yes 2 ☐ No after death Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af
To the Funeral D
completely filled I Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or livestigation, in this spatial, activities and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2012 ress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner 8. Dafe of Birth (Mbnth, Day, Year) If Under 2 9. Birthplace (State or Foreign **Funeral** 213-64-080 Months Days Hours Min. Country) Director 1 X M 2 □ F 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pega 1 and 2 should be filled within 72 hours efter death with the Maryland the Medical Examiner must be notified at Director 28e-f 1 Yes 2 No timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funerai 21202 08 238 E. Eager Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ō δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) el Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) abover of Heelth end Mantel Hygitem 27 is merked other other treumetic event, Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) ည . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dapartment of Important: If I any injury or o 1 Burial 2 Cremation 3 Removal from State oudar 4 ☐ Donation 5 ☐ Other (Specify) F/H-East . Signature of Funeral Service Licensee 22. Name and Address of Facility arch (Himore Part Y Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ aid disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami usa es the burlal-transit Hospital or Attending Physician: Tha lew raquires thet the deeth certificete be executed Due to (o) as a consequence of): resulting in death) Last ate hes baen signed by the ettanding physicien page 2 should be detachad for usa es the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2. No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2\No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funerel 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 \square Pending 1 Natural injury 24 hours after death.

Funarel Director: After letely filled in by the fur 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hours to the Funal completely fl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIARMIARA 31. Date filed (Month, Day, Year)

JAN 0 3 2013 32. Registrar's Signa State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42624 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2012 Ann Wallis Stitz December 11:05a [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 114 Warren Road Cockeysville **Baltimore** 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Funeral (Month, Day, Year) May 27, 1953 Director 217-62-6943 1 🗆 M 2 💢 F 59 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f aho within 72 hours after death with the Meryland Director 1 🗌 Yes 2 👿 No Maryland 1 4 1 **Baltimore** Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 114 Warren Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiana. Elementary/Secondary (0-12) College (1-4 or 5+) Plant Manager <u>Jessy Plant Systems</u> permit. Page 1 and 2 should be filed w Department of Health and Mantal Hygi Important: If item 27 is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joshua F. Cockey Doris Lilly Reidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Eric Stitz/husband 114 Warren Road Cockeysville.Maryland 21030 timore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 01/02/2013 Baltimore, Maryland 4 Donation 5 Other (Specify) Signiful Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of MAryland, Inc 299 Frederick Road Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory an shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ancer Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of). anding physicien and use as the buriel-transit or Attending Physician: The law requires thet the daeth certificate be axecuted Due to (or as a consequence of): resulting in death) Last bean signed by tha attanding physicien should be datached for use as the burie Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown Completed 1 Yes pega 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No. has 24 hours after death.

Funeral Director: After this cartificata lately fillad in by the funerel director, peg 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 A Residence 6 \square Other (Specify, 1 🗌 Yes 2 💢 No 욛 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide within 24 hours after des To the Funeral Director complately fillad in by th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hoapitai Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Znd, 2013 07235 who completed cause of death (Item 23a) (Type, Print) 1 Texas Station Ct. Suite 210, Timorium, MD Small ma. ONEGON 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Robert H. Scott 02:20 P.M VECEMBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/AAgnee HOSPITA 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Hours Months Min. 220-03-9995 1 🖾 M 2 🗆 F Director 92 Yrs. 05/03/1920 MD Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10c. City, Town or Location within 72 hours after death with the Maryland Director MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2938 Ellicott Driveway 21216 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me. Elementary/Secondary (0-12) College (1-4 or 5+) Fort Meade Fork Lift Operator 6th æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lillian Williams 2816 Bynum Overlook Dr. Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Garrison Forest 1/14/13 Owings Millls, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility}
Joseph H. Brown, Jr. Funeral
2140 N. Fulton Ave. Baltimore, Home PA MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ 4R-DIOGENIC disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner HEMIC Sequentially list conditions, Harry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of signed by the attending physician and defected for use as the burial-transit Exami that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 ☐ Probably 4 🗗 Unknown To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should to Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ms 2,2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHINTAN 900 CATON AUS, BALTIMORES, MD 21229 9BL 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State JANO3 2013 Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 20b, per fh, g935 1-3-13 sm State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alice Maud Stuart ^D23, 2012 1:20 P M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 311 Royal Oak Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 004-30-9159 1 🗆 M 2 📉 Director 82 04/21/1930 New Hampshire Usual Residence of Decedent shov death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl MD Harford Bel Air 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral US 21015 311 Royal Oak Drive Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 5 þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2XXNo Specify. White Specify "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed thent of Health and Mental H tant: If item 27 is marked ot jury or other traumatic even ္ဝ Laura M. Smith Harvey Dallas Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Walsh (son) 311 Royal Oak Dr. Bel Air, MD Baltimore, 20a. Method of Disposition 20h Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 Cremation Removal from State permit. Page Department o Important: If any injury or 2013 4 Donetion 5 Other (Speci Center 2012 New Hampshire 22. Name and Address of Facility Schimunek Funeral Home, Bel Air Signati 610 W. MacPhail Rd. Bel Air, MD Part 1. Ents the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a cons use as the burial-transit attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mor Month Day Year 2 46 Yes the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Nnknown been s Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 1 Yes filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner Other: 1 ☐ Ye 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Mann r of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie of person who complete ause of death (Item 23a) (Type, Print) O

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day,

32. Registrar's Signature

			Please	Type or Print in Bla	ack In	delible Ink	. Ensure	All Copie	s Are	e Legible	
_			For	State of Maryland				Mental Hy	giene	2012	42627
			State Registrar		Cer	tificate of D	eath		Reg. No		42021
ų	Physicia Medic		1. Decedent's Name (First, Middle, Las	Scawell				2. Date of De Month	ath Da	ay Year 3\ Zola	3. Time of Death 2 0513AM
T.	Examin		4a. Facility Name (if not institution, give	***	-1	4b. City, Town, or	Location of Deat	h	40	County of Dea	th
Topped Park	Funeral		5. Social Security Number 6. S		birthday)	If Under 1 Year Months Days	If Under 24 Hrs			9. Bir	thplace (State or Foreign
	Director			M20F 51	Yrs.	Months Days	Hours Min.	(Month, Da	Q a		MD
	ld over	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loc	cation		Duly W 1	741		10d. Inside City Limits
	a-f sh	Director	inn Jula	Bultin							1 Yes 2 □ No
	or 28		10e. Street and Number		NIE	10f. Zip Code			10g. C	itizen of What Co	ountry?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	by Funeral	442 Roundview	Rd.		2125			1154)	
	items items	Fun	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit	
36	after (I", or xamir	d by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No		_	Specify:	, ,		Specify: 12/	ack
21215-0036	atura cal E	Completed	15. Decedent's E	Year or Dates. ducation 1	6a. Deced	lent's Usual Occupa	ation		16b k	Kind of Business	/Industry
215	n 72 h an "n Medi	шe	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4 or 5+)	(Give F life, DC	kind of work done d O NOT use retired)	luring most of wo	rking	L 11		
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ž	should be file and Mental H 7 Is marked o raumatic eve		10 Informatio Name (Relationship (iroo Printh	401 14 11	- N	<u>oertina</u>	MOMINS	0/4	- T C4-4- 7	in Codel
Ma	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7	NI GOI	196. Mailin リルス	ROUNCILLE		Solto Mo		225	p code)
ē,	1 and of Hea item other		20a. Method of Disposition			sition (Name of	07.0	Date		ocation - City o	r Town, State
Ë	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donațion 5 ☐ Other (Speci	nemovariioni state		natory or other place MP+PM	1-9	-13	Lar	rsdowne	mo
Baltimore	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra once.	1	21. Signature Funeral Service Livin			. Name and Addres	s of Facility	~ - 11	1.	D	n 21229
<u>m</u>	20 E # 9		SMY / DI IN	W.	160	ry P. mara	ChFH &	to treat	il to	o rass	Ocito, MD
			23a. Part 1 Enter the disease, or comshock, or heart failure. List only o		o not ente	er the mode of dying	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
æ	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a other osiler	ati	(Sd)	01256	nor.	Li	reace	vaknows
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		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to for as a con explend	ce of):						
20	e executed sian and urial-transit	xam	Cause (Disease or injury that initiated events	C							
8	cian a	ä	resulting in death) Last	Due to (or as a consequent	ce on.						
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.89	nding use a	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		7			Ц	23d. Date of de	elivery
Box 68760	e atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live Birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown		Other (specify)	у			Month	Day Year
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σ.	requires that the death certificate be been signed by the attending physic should be detached for use as the b	Completed by Physician/Medical Examiner	Part II. Other significant conditions of	contributing to death but not resulting	ng in the u	indenying cause giv					o the cause of death? Probably 4 Unknown
rds	requir	etec	1	1 1 15	1	4.0		24a. Was			utopsy findings available
Records,	elaw ehasl ige 2 s	E G	brows	co para				auto perf	psy ormęd?	prior to death?	completion of cause of
<u>π</u>	an: Th tificate tor, pa	Be C	25. Was case referred to medical			26. Pla	ace of Death (Che	1 🗌 Yes	2,201	No 1 L Y∈	es 2 No
Vit.	ysicia Is cer direc	10 B	examiner? 1XX Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatier	Othe	or.	Home 5 ☐ Res	idence	6 ☐ Other (Spe	cify)
o	ng Ph fter th ineral	ë	27. Manner of Death ↓ Natural 5 ☐ Pending	28a. Date of injury 28 (Month, Day, Year)	Bb. Time of injury	28c. Injury work	y at	28d. Describe	how inju	iry occurred	
ion	tor: A	ifica	2 Accident Investigation	·			Yes 2 No				
Division of Vital	or At after of Direction by	Ser	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, tarm, str	eet, factory, office		28f. Location (ural Route Number,
	spita hours neral y filled	ical		rsician: To the best of my knowledge							
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Medical Certificate:		iner: On the basis of examination ar se Practitioner: To the best of my I							
	Vith Coal		29b. Signature and title of centifier	1		29c. License				ate signed (Mon	
		١	Mon Jon	man mp			330t1		DZC	१००४	31,2012
	3	\	30. Name and address of person who		Ba) (Type, F		or Ha	1-4:	300	1524	htanour
	Sta	l te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	e Car	4016	m Elo	Portol	Ove	- Just	11 11 11
	Registr		JAN 0 3 2013	Cenus B. A.	alle			,			

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after deeth.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the Inneal director, page 2 should be detached for use as the burial-transit Box 68760 P.0. Records, **Division of Vital**

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DHMH 17 Rev 06-2011

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December 25,201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 42630 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nijaporn Soodsamai December 27, 5:14р м 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 602 Chichester Lane Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 235-19-0803 Director 1 □ M 2 🛣 F Thailand 11/08/1949 63 permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23e or 28a-f show amy njury or other traumatic avant, the Modical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 🗆 Yes 2 🕅 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 Thailand 602 Chichester Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. δ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Communication Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Prapa Srisongkhram Sombun Viengsima 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 602 Chichester Lane, Silver Spring, Maryland 20904 Somsak Soodsamai - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 X Removal from State Everly Crematory 01/13/2013 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility Everly-Wheatley Funeral Home 21. Signature of Funeral Service Licensee Hough. 1500 West Braddock Road, Alexandria, VA 22302 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death

18 Months Physician/ Carcinoma of Lung Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be exacuted attending physician and for use as the burlal-transit Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown ☐ Ectopic pregnancy Month 5 Other (specify) Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attanding Physicien: The lew requires to 24 hours after death.
 Funarel Director: After this certificate has been sign a Funarel Director: After this certificate of the physicial physicial has been sign. Records, 1 ☐ Yes 2 ☐ No 3 🗡 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. D39979 ause of death (Item 23a) (Type, Print) ess of person who completed 1400 Forest Glen Road, Silver Spring, Maryland 20910 William K. Kelly, M.DY 31. Date filed (Month, Day, Year)
JAN 0 3 2013 32. Registra 's Signature State Registrar

WILLIAM 12-09283 UNK UNK

SPENCER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 42631

		1- For State Certificate C	of Death	Reg. I	No.	1200	
Physicia	ın/	Decedent's Name (First, Middle,Last)		Date of Death Month Da	3.	Time of Death	
edical Examir		William Christopher Spencer		December 6,	2012	0151 hrs	
		 Facility Name (if not institution, give street and number) 5611 Sweet Air Road 	4b. City, Jown, or Location of Death Baldwin Jacksonville		4c. County of Death Baltimore County		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_ `	MM/DD/YYYY) 9 Birthp	Raltimore	
Director	Ì	220-48-8168 1XM 2 F 62	rs.	July 14,	1950 Count	Maryland	
*		Usual Residence of Decedent 10a State 10b County 10c City, Town or Loc	ation		110	Od. Inside City Limits	
0W 80y		Maryland Baltimore County Baldwin	ation			Yes 2X No	
yland 1-f sho	횼	10e. Street and Number	10f. Zip Code	100	Citizen of What Country		
death with the Maryland or items 23a or 28a-f show must be ootified at ooce.	Director	5611 Sweet Air Road	21013	1.19	United States		
with the ns 23a			Vas Decedent of Hispanic Origin? (S		14. Race - America	n Indian, Black,	
death or item	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	:	
-	J.	3 XWidowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:		Open.y.	ite	
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e, MD I and 2 sho Health and item 27 is	-	2	osition (Name of cemetery,		Oc. Location - City or To		
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and N Important: If item 27 is n ojury or other traumatic		1 Burial 2 X Cremation 3 Removal from State	other place) and Se	aturday, 22,2012	Harford Forest Hil	l County	
		4 Donation 5 Other Specify: Cremation 21 Signature of Funeral Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Firey L. Cair, Sr. Crematical Control of Service License of Serv	Services, Inc. Dec.	22,2012			
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Physician		Sa. Part. Enter the disease, or complications that caused the death. Do not enter				Approximate Interval Between Onset and	
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1		or condition resulting in death) Due to (or as a consequence of):					
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S, P.C nires that 1 signed I d be deta	ed by				2 No 3 Proba		
cords law requi	plet			24a. Was an autopsy	prior to cor	psy findings available mpletion of cause of	
Records, The law requir, ficate has been si	Completed			performe	No 1 ✓ Yes	2 No	
tal Rection: The certificate ector, page	Be (25. Was case referred to medical examiner? Hospital: I tagetiest 3 FR/Outset	26. Place of Death (Check				
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Division of Vital tal or Atteoding Physician: Is after death. **I Director: After this certicled in by the funeral director.	ion:	1 Natural - (Month, Day, Year)	:51 am 1 Yes 2 X No		al house fi	ire	
IVISION OF Atteodath The Atteodath The Atteodath The Atteodath The Atteodath The Atteodath	icat	2 Accident investigation 28e. Place of Injury - At home, farm, s	. J1 am	28f. Location (Str	eet and Number or Rura te) 5611 Sweet	al Route Number, City	
ital or	Certification:	Suicide 6 Could not be determined (Specify) Single Fam	ily Home	or Town, State	o)5611 Sweet ville,MD.	Air Rd.	
Hosp 24 hos Fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death of	curred at the time, date and place, ar	nd due to the cause(s) and manner as stated	d.	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifit within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.					
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d. Date signed (Mont December 6, 2012		
Les		Japan Routhall, MI)	U.C.NI.E.				
atho		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	000 W. Baltimore Street, Bal	timore, MD 212	223		
	tate	De Deside de Circular	· ·				
Regis		I IAM D 3 / HIS / Warehas As Lawrence					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G935 1/10/2013 JH
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2012 42632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 26, 2012 Year Jean Shirley 10:00 P M Marilyn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Eldercare
5. Social Security Number <u>Severna Park</u> Anne Arundel 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Director 111-16-7172 1 □ M 2 🕅 F Yrs March 24, 1926 New York 86 permit. Pege 1 end 2 should be filed within 72 hours after death with the Meryland Depertment of Heelth end Mentel Hygiene. Importent: if item 27 is marked other than "neture!", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Chestnut Hill Cove 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 875 Chestnut View Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3

Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Appenzeller William Everett Smith Irene Marie 19a. Informant's Name/Relationship (Type, Print) **ROBINSON** Jean Robertson (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 875 Chestnut View Court Chestnut Hill Cove Maryland 21226 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 01/02/2013 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MOO-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examiner Due to (or as a consequence of): within 24 hours after deeth.

To the Funeral Director: After this certificate hes been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-tranait or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗆 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗔 Pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and file of certifier 29d. Date signed (Month, Day, Year) 127 00073574 son who completed cause of death (Item 23a) (Type, Print)
NINEOV 9. St. 01 Veterance Wery, Millersville 30. Name and address of person 10 31. Date filed (Month, Day, Year)

JAN 0 3 2013 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42633 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Smith 2012 Stephen J. 9:00 A M Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A Baltimore Hopkins Bayview Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Director 214-94-7464 33 1 № M 2 🗆 F Yrs Usual Residence of Decedent 1979 Maryland 23. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 No. Yes 2 No. N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 USA 24 Griffis Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 ☑ Never Married 2 ☐ Married ģ Maryland 21215-0036 f Hygiene. other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked o Renford Smith Jr. Mary Simms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 i 1723 Marley Avenue, Glen Burnie, Maryland 21061 Buddy Smith (uncle) Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/31/2012 Glen Burnie, MD 21061 Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3714 Mountain Road, Pasadena, Maryland 21122 P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Medical Due to (or as a con uence of): Examiner 19 W Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Chronic Hypoventilation The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 33 years ere bra 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obesity 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 W No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: |2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the basis of my knowledge. Seath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier D0037654 MD

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person w

31. Date filed (Month, Day, Year)

JAN03

John

Box 68760

P.O.

Records,

Division of Vital

no completed cause of death (Item 23a) (Type, Print)

MD

505

Serlemit

2033 Penderbrooke Dr. Crownsville, MD 21032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month /2 Year 2 Medical 4a. Facility Name (if not institution, give street and number) 45. City, Town, or Location of Death 4c. County of Death Examiner Tate House <u>Linthicum</u> <u> Arundel</u> nne 8. Date of Birth (Month, Day, Year) 3 / 1 7 / 1 9 4 7 Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min Director 1 □ M 2 🔯 F 176-36-8305 65 PA permit. Page 1 and 2 should be filad within 72 hours after death with the Maryland Department of Health and Mantal Hyglane. Important: if item 27 is markad other than "natural", or itams 23a or 28a-f shor any injury or other traumatic event, the Model Examine counts the notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Upper Marlboro Prince Georges 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 319 Radiant Court 20774 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Assembler Ford Electrics 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wade Jenkins Mattie L. Johnson Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Rucker daughter 319 Radiant Ct Upper Marlboro MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pottstown PA Highland Memorial 12/29/12 4 ☐ Donation 5 ☐ Other (Specify) Service Licensee 22. Name and Address of Facility Harman Funeral Service 21. Signatu 7221 Grayburn Dr Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final UNG Enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami certificate hes bean signed by tha attanding physician and liractor, page 2 should be detachad for use as the burlei-transit To tha Hospital or Attanding Physician: The law requires that the daeth certificate be axecuted ause (Discase or injur) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Pregnant at time of death Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? After this certificature funaral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1 Yes 2- No |요 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred House Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No il Director: Af ad in by tha fu Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e within 24 hours af To the Funeral Di completely fillad in Medical 1-Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of Aertifier and address of person who completed cause of death (Item 23a) (Type, Print) 0 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 2012 NATHAN SADOWSKY 02:45P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death BALTIMORE 1011 FUSELAGE AVENUE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 170-03-1756 Days Country) Director 93 1 X M 2 □ F 10/01/1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f showary injuy or other traumatic event, the Medical Francia. 10c. City, Town or Location Director 10d. Inside City Limits **BALTIMORE** BALTIMORE MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1011 FUSELAGE AVENUE 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ۾ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 🗌 No 1 ☐ Yes 2 X No Specify: WHITE Be Completed 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **PROGRAMMER** COMPUTERS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည UNKNOWN SADOWSKY UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NORMA WITHROW/FRIEND 1011 FUSELAGE AVENUE, BALTIMORE, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEM 01/02/2013 OWINGS MILLS, MD 21. Sign ture Funeral Service Centre 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, INC. MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card ac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ron Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last attending physician and for use as the burial-tra-Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy perform 2X No 1 ☐ Yes 2 X No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ည 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? After 28d. Describe how injury occurred 1 Natural 5 Pending eral Director: Al filled in by the fu 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the tirne, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and titt 8 who completed cause of death (Item 23a) (Type, Print) filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

10014 sta Catherine			ndelible Ink. Ensure All Copie artment of Health and Mental H	es Are Legible. lygiene 2012 4263
Physici dical Exami	an/	Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death Tindal	2. Date of Death
		4a. Facility Name (if not institution, give street and number) 7464 Weather Worn Way	4b. City, Town, or Location of Death	Bookinger ed, Ed IE
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 218–96–8198 1 M 2 V F		s. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Baltimore, MD 21215-0036 permit. Pages I and 2 shoulo be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatie event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 8265	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No specify: 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret 18.Mother's Name	work done 16b. Kind of Business/Industry lired) Resturant e (First, Middle, Maiden Surname) Dara Delpy Rural Route Number, City or Town, State, Zip Code) Lander 10c. Location - City or Town, State H 2013 Handrey, MD
ath certificate be executed attending physician and or use as the bunial - transit	Medical Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter U. Jorlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	cation and Cocaine Use on: on: 28a-f,per me,g937 3-7-1	Between Onset and Death
P.O. Box 68760 res that the death certificate b signed by the attending physic be detached for use as the bu	by Physician/I	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 1 Live birth 4 Pregnant at time of d 9 Unknown	2 Fetal death 3 Ectopic pregna	,
tal Records, P.O. Box cin: The law requires that the death certificate has been signed by the att ector, page 2 should be detached for	Completed			24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Division of Vital Records, P.O. Box 68760, Content Bospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Lineral director, page 2 should be detached for use as the burial - tra	edical Certification: To Be	Suicide 4 Homicide 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	28b. Time of Injury 28c. Injury at Work? fd 12:30 pm 1 Yes 2 No home, farm, street, factory, office building, etc. in single family house dge, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred	ng Home 5 Residence 6 Other: Scene 28d. Describe how injury occurred unknown 28f. Location (Street and Number or Rural Route Number, Citor Town, State) 7464 Weather Worn Was Columbia, MD. d due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)
		29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Iter	· ·	December 31, 2012
7	ate	Donna M. Vincenti, MD Assistant Medical Exa 31. Date filed (Month, Day, Year) 32. Registrar's Signal	miner 900 W. Baltimore Street, Baltin ture	more, MD 21223

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5, per fh, 7935 1-25-13 cm State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death Decement's Name (First, Middle, Last) 2. Date of Death Physician/ Month OAN 130 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 318 Hollyberry Road Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Vear Director 1 □ M 2 🕱 F 73 Jan.5,1939 Connecticut or than "netural", or items 23s or 28s-f show the Medical Examiner must be notified at fliad within 72 hours aftar death with tha Maryiand 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severna Park 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21146 318 Hollyberry Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be fliad with Department of Health and Mental Hygier Important: if item 27 is marked other to any Injury or other traumatic event, the once. 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဍ Leon A. Whiteley Winifred Ackerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Hollyberry Road Severna Park, Maryland 21146 Kendal Cohen/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 KCremation 3 Removal from State Metro Crematory, Inc. 12/31/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) of Funeral Service Licensee StephanieCuster 22. Name and Address of Facility Cremation Society of Maryland, Inc 21. Signat 229 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to for as a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury) Due to (or as a consequence of): ad by the attending physician and detached for use as the buriai-transit Hospital or Attending Physicien: The law raquires that the daath certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown within 24 hours after death.

To the Funaral Director: After this certificate has baen signad by i complately filled in by the funaral director, page 2 should ba detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 🗆 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signature and title of certified 29b. 29d. Date signed (Month, Day, Year) 38 Mae 3 (201) Name and address of person who completed cause of death (Item 23a) (Type, Print) E 31. Date filed (Month, Day, Year) JAN 0 3 2013 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. cedent's Name (First, Middle, Last Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 149 Anne Arundel Olen Glen Burnie Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 213-12-6454 94 Director 1 □ M 2 🗓 F Aug. 7, 1918 Canada 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evancinar must be notified at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie Maryland Anne Arundel 1 🗆 Yes 2 💢 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 149 21061 United States 0len Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 ☑ Yes 2 ☐ No 1943If Yes, Give 1945 þ Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify White Specify: 1945 Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be Page 1 and 2 should be filed ament of Health and Mental Hy, ant: if Item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Benjamin Marshall Montgomery Janet McGarvie Munn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jenny M. Kaltenbach / Daughter 612 North Bend Road, Baltimore, Maryland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a Department of h Important: if ite 20c. Location - City or Town, State 1 D Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 12/31/2012 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc any 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or commutations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed buriai-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by filled in by the funeral director, page 2 should be Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other 잍 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manuel Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completely filled in by the form ☐ Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 [M'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar filed (Month, Day, Yea, N 0 3 2013

12-09794 David Alan Tedder

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	-	For State		Ce	rtificat	te of i	Death				Reg. No.			
Physicia Cal Exami	ın/	egistrar Decedent's Name (First, Midd David Alan Tec								Date of De Month Decembe	Day er 23, 201	3. Time of Death 2219 hrs		
		4a. Facility Name (if not institution		mber)		41	o. City, Town, or Parkville	Location of	f Death	eath 4c. County of Death Baltimore County				
		7808 Highpoint Road 5. Social Security Number	6. Sex	7. Age (In yrs.	last birtho	day)	If Under 1 Year	If Under	r 24Hrs.	8. Date of B	irth(MM/DD/	YYYY) 9. I	Birthplace (State or	
Funeral Director		213-50-6276	1 M 2 F	55		Yrs.	Months Days	Hours	Min.	10/16	/1957	For	eign Country) Japan	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town o	r Locatio	n						10d. Inside City Limits	
	اج	Maryland Balti	imore	Par	kvil	.le							1 Yes 2 No	
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number					10f. Zip Code				10g. Citizen		ountry?	
th the 23a or	— L	7808 Highpoin		edent Ever in U	18	13 Was	21234 Decedent of His		in? (Spe	cify Yes or N	U.S		nerican Indian, Black,	
ath wi	Funer	11. Marital Status 1 Never Married 2 N			,	If Ye	s, specify Cubar	, Mexican,	Puerto R	tican, etc.)		White, etc		
fter de	Dy Fu		vorced If Yes, Give Yes	ar 21			Yes 2 No						White	
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15-0036 filed within 72 hours after of a Hygiene, ed other than "natural", of the Medical Examiner nor the Medical Examiner of	Completed	Elementary/Secondary (0-12	2	1-4 01 5+)	Τe	echn:	ician				Elec	ctron	ics	
5-00 ed with tygiene other	5	17. Father's Name (First, Middle	e, Last)		1			18.Mother	's Name (First, Middle	, Maiden Su	rname)		
21215 nuld be file Mental H marked c event, t	Be	Marvin Tedde			Lion	Mailing	Address (Stree	Mar	jorie	Long	umber. City	or Town, St	ate, Zip Code)	
그 음 모 호 프	2	19a. Informant's Name/Relation Bryan J. Tedde		Son									nigan 49663 or Town, State	
re, ME s 1 and 2 s of Health as of item 27	=	20a. Method of Disposition		20b	cremato	ry or oth	tion (Name of ce er place)	metery,				cation - City	or Town, State	
Baltimore, permit. Pages 1 as Department of Hee Important: If ite		1 Burial 2 Crematic		rom State Cr Ce	~emat	lon	Marylar	nd		29/12			Maryland	
taltii rmit.] epartm aports jury o		21. Signature of Funeral Service	e Licensee			22. N	ame and Addres	s of Facility					apel, P.A.	
		23a. Part I. Enter the disease,	MULT mplications that	caused the deat	th. Do not	t enter th	ne mode of dying	, such as c	ardiac or	respiratory a	arrest, shock	or heart	and 21214 Approximate Interval Between Onset and	
Physician //Medical		failure. List only one caus	e on each line.										Death	
Examiner		Immediate Cause (Final diseas or condition resulting in death)		a consequence										
	_	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence	of):									
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of Vital Records, P.O. Box 68: ing Physician: The law requires that the death certifi After this certificate has been signed by the attending funeral director, page 2 should be detached for use as 1	Physician/	past 12 months?	4 Preg	nant at time of	death 5		her (Specify)							
BO) ie death the att	hysi	1 Yes 2 No 9 U	Jnknown 9 Unki		t resulting	n in the I	inderlying cause	given in P	art I.	23e. Di	d tobacco us	se contribut	e to the cause of death?	
Division of Vital Records, P.O. is or Attending Physician: The law requires that the started redath. **Ab Director** After this certificate has been signed by led in by the funeral director, page 2 should be detact	全	Chronic Alco		to death but no	t resulting	g III (110 C	211,007.7,11.19	3		1 🔲	Yes 2	No 3	Probably 4 🗹 Unknown	
ds, equires	Completed									24a. W	as an topsy	24b. Wer	e autopsy findings available to completion of cause of	
e law re has b	g									pe 1 ✓ Ye	rformed? s 2 No	deat	h? Yes 2 No	
I RG III: Th rtifical tor, pa	ပ္မ	25. Was case referred to medi	cal				26.Plac	e of Death						
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SiOF Attend r death. ector:	cati	2 Accident In	vestigation 28e Pla	ace of Injury - A	t home, fa	arm, stre	et, factory, office	building, e	etc.			d Number o	or Rural Route Number, City	
Division Rospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	4 Homicide	ould not be etermined (Specif								n, State)			
Division of Vital Records, To the Hospital or Attending Physician: The law require within 24 hours after death. Tompletely left in by the funeral director, page 2 should	Sal	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the basi	est of my knowl s of examination	ledge, de n and/or i	ath occu	irred at the time, ation, in my opini	date and p on, death c	lace, and occurred a	due to the out the time, d	ause(s) and ate and plac	l manner as ce, and due	stated. to the cause(s)	
To the within 2 To the complet	Medical	29b. Signature and title of cert	and manne	r stated.				nse numbe					(Month, Day, Year)	
	-	ane 52					0.0	.M.E.			Dece	ember 24	1, 2012	
0		30. Name and address of pers) W. Baltimo	re Stree	t Baltis	more MD	21223			
3		Ana Rubio M.D., Ph 31. Date filed (Month, Day, Ye		t Medical Ex Registrar's Sign				16 20166	i, Dailli	HOIE, WIL	_ 1220			
	state stra	44410 0	วกาว 🔏	Registrar's Sign	A	bau	Les .							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month iSA Physician/ 21117 M Medical 4a. Facility Name (if not institution, give street and number)

5. Social Security Number 6. Sex 7. A 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAGIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 579-25-0879 1 M 2 X F 50 May 03, 1962 Vietnam ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health end Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f showing or other traumatic event, the Musical Examinar must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20904 u.s.A. 2005 Aventurine Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Asian Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Beauty Care Nail Technician Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Trinh Thi Lieu Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2005 Aventurine Way, Silver Spring, Maryland 20904 Son Tu - Companion Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 a
Department of H
Important: If its
any injury or ott 1 X Burial 2 Cremation 3 Removal from State 01/07/2013 Silver Spring, Maryland Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 0730 enne 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final LIVER FM LUPE AWTE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner TER! Sequentially list conditions, if any, leading to himselfate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 Ho
9 Unknown Month Day sate has been signed by the cage 2 should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ JSPLANT 1 Yes 2 No 3 Probably 4 Unknown Records. Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Accident
2 Accident
3 Suicide 5 Pending Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 156206 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STENCENSON LANE, APT. BY, TONISON, MD21204 00 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-05943 2012 42641 State of Maryland / Department of Health and Mental Hygiene Oscar Lorenzo Velasco-Montano 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1708 hrs August 8, 2012 Medical Examiner Velasco Montano Lorenzo 0scar 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Frederick 4105 New Design Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min Months Davs Hours Director 12/28/1981 Bolivia 1 X M 2 30 697-01-7381 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ì 1 Yes 2 X No 28a-f show Springfield VΑ Fairfax Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.
tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 22150 Bolivia 5814 Amherst Ave. 14. Race - American Indian, Black Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? 1 Never Married 2 Married Yes 1X Yes 2 No specify: Bolivian Specify: Hispanic If Yes, Give Year Widowed 4 Divorced 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Laborer 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florencia Montano Mirtha Velasco Rivas Oscar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 5814 Amherst Ave. Springfield , VA 22150 Marisol Montano - Aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 2 X Cremation 3 Removal from State 12/26/2012 Falls Church, VA permit. Page Department o National Crematory Donation 5 Other Specify 22. Name and Address of Facility Demaine Funeral Home ignature of Funeral Service Licensee 5308 Backlick Rd., Springfield, VA 22151 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a, Homicidal Violence of Undetermined Means Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the Dav Live birth Fetal death 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown ⋧ Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 1 🗸 Yes Yes 2 2 No this certificate 26 Place of Death (Check only one or Attending Physician: 25. Was case referred to medical of Vital Be examiner? Hospital: 1 Inpatient 2 Residence 6 V Other: Scene Nursina Home 5 ER/Outpatient 3 DOA 1 V Yes No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Inflicted Certification: FOUND: Division Natural Yes 2 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: Director: d in by the f Aug 8, 2012 1707 hrs 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State)
Found, south of 4105 New Design Road, Frederick, MD determined (Specify) Found in woods 4 V Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 9, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD Assistant Medical Examiner State Registrar

Wilhelm, John

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

traumatic event, the Medical

permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any injury or other traur

Physician /Medical

Examiner

burial-tran

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To th. within &

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ne Funeral Director: /

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The law requires that the death certificate be executed

P.O. Box 68760,

or Vital Records,

Division Hospital or Attending

I 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show

3altimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) December 30 2012 **Physician** John Edward Wilhelm 9:30A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore County Franklin Woods If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 7 1929 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Hours Days 1 □ M 2 □ F Baltimore, Maryland 83 212 28 5898 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore County Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 USA 7846 St Thomas Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1√]Yes 2□No IfYes, Give Year or Dates: **Kore**a 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Heating & Air Conditioning INc 12 Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leona Unknown Harry E Wilhelm ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7846 St Thomas Drive Baltimore, Maryland 21236 Margaret C Wilhelm (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Oak Lawn Cemetery January 2, 2013 21. Signature of Funeral Service Licensee Lassann Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw 23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner monic obstructive Physician/Medical berti Lung di IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed venticulou 1 Yes 2 No 25. Was case referred to medical examiner?
1
Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R156119 ress of person who impleted cause of death (Item 23a) (Type, Print) Frenklin Woods 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0005 AM Lillian Elizabeth Winkler ECEMBER 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** URSING Home AVKE 1 ٤ GRACE 1512 ENS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** April 4,1919 Laraviille, Maryland 1 🗆 M 2 😾 F 93 215 01 2693 Director Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Baltimore County Marvland Baltimore 10f, Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 21236 14 Virginia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 2 No Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping-Own Home N/A Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Anna Flossman Henry Leubecker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Oakway Court Joppa, Md. 21085 Steve Winkler (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State January 4, 2013 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 22. Name and Address of Facility Signature of Funeral Service Licenses Lassahn Funeral Home Inc Baltimore, Maryland 7401 Relai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical onsequence of) or as a Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed at hours after death. s been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death g 🗌 Unknown 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s 2 XNo 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical JINKIER, examiner? Other: 🖊 No ER/Outpatient 3 DOA မှ 1 🗌 Inpatient 2 🔲 rsing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dea 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work' Natural 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) M 91 32. Registr State

Registrar

			Please T	ype or Print in Black AMEND TTEM#20b p State of Maryland / De	c Indelible In	k. Ensure A	U Copies A	re Legible.	
		1	For State Registrar		Certificate of		Reg. i	2012	42644
П	Physicia		1. Decedent's Name (First, Middle, Last) Barbara	Wonqus			2. Date of Death Month	Day Year	3. Time of Death 7:50 pm
d	Medic Examin		4a. Facility Name (if not institution, give str 3812 Gwynn (1	or Location of Death	-	4c. County of Deat	
	Funeral Director		5. Social Security Number $^{\prime}$ 6. Sex $^{\prime}$ 218-46-9388 1 $_{\Box}$	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year		thplace (State or Foreign untry)
	Meryland 28a-f show offlied et	ector	Usual Residence of Decedent 10a. State 10b. County Political	noce Gwy	N 1	,	107 - 1	<u> </u>	10d. Inside City Limits 1 ☐ Yes 2 🗹 No
	with the M 23e or 26 ast be not	Funeral Director	10e. Street and Number 3812 Gwynn C	ak Avenue	10f. Zip Code	207	10g.	Citizen of What Co	puntry?
920	1 and 2 should be filed within 72 hours after death with the Meryland F Heelth end Mental Hyglene. If Heelth and Mental Hyglene. Item 27 is merked other then "neture!", or Items 23e or 28a-f sho other treumetic event, the Medical Examinar must be notified at	۾		2. Was Decedent Ever in U.S. Armed Forces? 1 — Yes 2 Deno If Yes, Give Year or Dates.	13. Was Decedent of I	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
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Maryland	should be filed within 7: end Mental Hyglene. Is merked other then reumetic event, the Mr	2		erricks		Eliza	beth 1.	Garne	
	and 2 shou Heelth end tem 27 is m		Hrden E. Derric	KS/5341 38	12 6wyni	and Number or Furn	le. wyn	n Uck,	mD 21207
Baltimore,	0 0 = =		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Re □ Donation 5 □ Other (Specify)	emoval from State	Disposition (Name of Grematory on other pla	(*) 1/4	2013 20c.	altima	Town, State
Balti	permit. Page Department Importent: I eny injury o		21. Signature of Funeral Service Lioun.	Leen	22 V 00000	Soffa . G	reene Fi	ineral	Services D 2/229
5	Physician/	2 7	23a. Part 1. Intel the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	t enter the mode of dyi	ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
4	Medical Examiner		disease or condition resulting in death)	Due to (or is a consequence of)					
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Irijury	Due to (or as a consequence of)	:				
	e executed clan and vurial-transit	I— I	that initiated events c. resulting in death) Last	Due to (or as a consequence of)	:				
3760	ath certificate be ettending physicis for use es the bu	Medic	IF FEMALE:					1	
. Box 68760	e de the	Completed by Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3	псу		23d. Date of de Month	elivery Day Year
ds, P.O.	requires that th been signed by should be detac	ed by P	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause g	iven in Part I.			o the cause of death? Probably 4 Unknown
Division of Vital Records,	The law rec ate has bev page 2 sho	Somple					24a. Was an autopsy performed 1 \(\text{ Yes} \) 2	prior to	topsy findings available completion of cause of
/ital	sicien: The la certificate ha lirector, page	To Be (25. Was case referred to medical examiner? 1 Yes 2 W No	ospital:	T _{O*}	Place of Death (Chec			-16.0
on of \	tending Physical death. tor: After this eath the funeral disperse of the funer	Certificate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury 28b. Tir	ne of 28c. Inju	ry at	28d. Describe how in		any)
Jivisio	ء ڇُنڍُ ⊆		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fam- building, etc. (Specify)	n, street, factory, office		28f. Location (Street City or Town, Str		iral Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	(Check 2 \(\subseteq \text{ Medical Examine} \)	ian: To the best of my knowledge, de r: On the basis of examination and/or i Practitioner: To the best of my knowle	investigation, in my opin	ion, death occurred a	it the time, date and pla	ace, and due to the	cause(s) and manner stated.
	To the Vithin 2 to the comple		29b. Signature and title of certifier	ha ma	29c. Licen:	se number	29d.	Date signed (Mont	
~)		30. Name and address of person who cor	npleted cause of death (Item 23a) (Ty	/pe, Print)	51, 1	- 1J9	1	2013
1	Sta Registr		31. Date filed (Monte Day) (Sep.) Sep.	32. Register's Signiture	Sye, A.		ives off	<u>4 DUR</u>	
	3.0								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day 26 2012 December Physician/ 8:26 Edgar Weathers Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford <u>Upper Chesapeake Medical Center</u> Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Security Number **Funeral** Hours 65 266-90-6857 Director 1 X M 2 □ F Florida May 20,1947 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 🎗 No Edgewood Harford Maryland 10g. Citizen of What Country? 10e. Street and Number 21040 United States 1414 Harford Square Dr., J Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Mental Hygiene. narked other than Elementary/Secondary (0-12) 12 College (1-4 or 5+) Handy Work Handyman Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If Item 27 is marked ot any injury or other traumatic ever Jeffries Mary Louise Weathers Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1414 Harford Square Dr., JCourt, Edgewood, MD 21040 Lauranne Weathers / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. | 12/28/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury December Due to (or as a consequence or): ttending physician and or use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown P. 0. To the Hospital or Attending Physiclan: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Thomas 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No Investigation Weathers, 6 ☐ Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number DOT5734 Cyntua Sariau MD 500 upper Chesepeake Dr. Belair MD 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MHMA Soriano MD 32. Registra 's Sign State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 gay 2012 Karen Waters 3:25 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 215-84-3621 Director 1 □ M 2X F 51 Yrs 05/20/1961 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f showeny injury or other traumatic event, the Medical Examiner must ha matitized of 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director MD N/A Baltimore 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5348 Cordelia Ave 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Š ☐ Yes 2 🖾 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5yrs Elementary/Secondary (0-12) Kiddie Castle Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Emanuel Waters, Jr. Laverne Janice Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laverne Waters 5348 Cordelia Ave. Baltimore, MD 21215 (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/7/13 Millford Mill, King Park 4 ☐ Donation 5 ☐ Other (Specify) MD Signature of Funeral Service Licenses ²²Nosephren: Brown Jr. Funeral Home 2140 N. Fulton Ave. Baltimore, MD PA 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate name. Enter Indentying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be deteched for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month g Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tes 2 No 3 Probably 4 Unknown Director: After this certificate has been side in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Dice Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospitel or Atte within 24 hours after dea To the Funeral Director completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 nly one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) J0071287 Name and address of person who completed cause of death (Item 23a) (Type, Print) . # 4105, Balthuere, MD 21204

State

31. Date filed (Month, Day, Year)

JAN 0 3 2013

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 28. Physician/ Mary A. Webster 2012 9:30p M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rock Spring Village Harford Forest Hill If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Director 217-24-5349 86 1 M 2 XF Vrs 09/23/1926 Maryland parmit. Page 1 and 2 should be filad within 72 hours aftar daath with the Maryland Dapartmant of Haalth and Mantal Hyglena. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evaninat must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Forest Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1 Colgate Drive Apt. 413 21050 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker in home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Hinder Helen Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Teresa W. Smith (daughter) 211 S. Rogers St., Aberdeen, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/2013 Emory Methodist Cemeter 4 Donation 5 Other (Specify) Street, Maryland 21. Signature of Funeral, Service Licer 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury signad by the attanding physician and deadatachad for usa as the burlal-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed To tha Hoapital or Attending Physician: Tha law raquira within 24 hours aftar death. To the attrificate has baan si complataly Euneral Director: After this cartificate has baan si complataly illiad in by tha funaral director, paga 2 should Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, 1 Yes Other: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 155550 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at work? Certificate: 1 Natural 2 Accident 5 - Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signeture and title of certifi 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dance Schwartz 999 Hospitali 31. Date filed (Month, Day, Year) State Registrar 2 de

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Noreen O'Hara Welch 1250 M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 073-30-6035 Director 1 🗆 M 2 🔼 F Yrs 74 01/02/1938 New York Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mertal Hygiene. Important: If time ZT is anacked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Silver Spring Maryland Montgomery 1 Yes 2 No ۵ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 94 Eldrid Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ۾ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Nicholas Caggiano Hanorah O'Hara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 94 Eldrid Drive, Silver Spring, Maryland 20904 James S. Welch, Jr.- Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 01/09/2013 Brentwood, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses Katrina 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Embolus disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Metastatic Adenocarcinoma Sequentially list conditions. Examine rany, leading to initionate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 \(\square\) No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🕅 No Other: 1 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after death. 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ò To the Hospital of within 24 hours at To the Funeral D completely filled it Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D70144 December 31, 2012 ile 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mike Murray, 1500 Forest Glen Road, Silver Spring, Maryland 20910 M.D.,

Registrar

State

31. Date filed (Month, Day, Year)

JAN 0 3 2013

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Frederick Joseph Wetzel, Jr. 2:37 P M Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 50 Briarwood Road Catonsville 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) February 20, Hours Min Director 216-70-3092 54 1 🛛 M 2 🗆 F Usual Residence of Decedent Balt.,Maryland 1958 ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 🗆 Yes 2 🎦 No 10f. Zip Code 21228 10e. Street and Number 10g. Citizen of What Country?
United States Funerai 50 Briarwood Road of America 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 KM Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. white Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Maryland State (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Law Enforcement Be 17. Father's Name (First, Middle, Last) of Health and Mental H 18. Mother's Name (First, Middle, Maiden Surname) Frederick Joseph Wetzel, Sr. Lola Heiliger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lou-Ann Wetzel/ wife 50 Briarwood Road Catonsville, Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January Date permit. Page 1 Department of Important: if it any injury or o **₹** cemetery, crematory or other place)
Evans, Funeral
Chapel – Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 2013 21. Signat@re / Funeral Service Livensee 22 Name and Address of Faultives Funeral and Cremation Center, P.A. 10 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami g physician and as the burial-trans Cause (Disease or injury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 33 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Pregnant at time of death Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s ours after death. eral Director: After this certificate I filled In by the funeral director, page performed 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 🗖 No မြ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge death accurred at the firm, date and place, and due to the cause(s) and manner at etaled. 29b. Signature and title of certifier 29d. Date signed (Monjh, Day, Year) completed cause of death/(Item, 23a) (Type, Print) Dr. Enser W. CATON AVE BALTIMORE 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EDWIN DONALD WAYSON. JR. Month DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN BALTIMORE OSEDALE HOSPITAL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 220-70-0597 Director 1 X M 2 □ F Maryland March 21, 1957 28a-f shov 10a. State 10b, County with the Maryland 10c. City, Town or Location 27 is marked other than "natural", or Items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore 5 4 1 Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3 Horney Court 21221 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 Married Black, White, etc. 1 and 2 should be filed within 72 hours after of Heelth and Mental Hygiene. Item 27 is marked other than "natural", or 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates. 1977-79 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Police Dept. Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edwin Donald Wayson, Sr. Jean Kay Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean K. Wayson (Mother) 3 Horney Court, Baltimore, Md. 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State cemetery, crematory or other place)
Bayview Crematory, Inc. 1 Burial 2 X Cremation 3 Removal from State 12/29/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 M00175 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ RESPIRATORY Medical resulting in death) Due to (or as a consequence of): Examiner ATERAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) RESPIRATORY for use as the burlel-transi MUSCLE resulting in death) Last Due to (or as a consequence of) Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month 5 Other (specify) Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director. After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 XNo **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 29b. Signature and title of certifie 29c. License number pramova MD DECEMBER 25, 2012 RES 0000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 29, 2012 **Physician** 06:00A M Irene G. Weiman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Lansdowne 801 Rambo Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours 1 □ M 20XF 213-34-4618 76 April 19,1936 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Show th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, I'm Medical Evanina: must be netified at 1 ☐ Yes 2 X No Lansdowne MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with USA 21227 Funeral 801 Rambo Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5th Home Maker Own Home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygis Important: If Item 27 is marked other if any injury or other traumatic event, III. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Marie Dodson Columbus Christopher Walker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aurdrea Weimen / Daughter 2336 York Road Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet.Cem. Jan. 11,2013 Crownsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee 2719 Hammonds Ferry Road Lansdowne, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) IN FARCTION MYOCARDIAL hysician ACUTE /Medical Due to (or as a consequence of): Examiner DISEASE CARDIOVASULAR HIVERTENSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Exami and burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a ☐Yes 2 No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral (28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 17753 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 POTER STREET, BALTIMORE, MD 21225 M.D. DHARMASENA, 31. Date filed (Month, Day, Year)

JAN 0 3 2013 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jack Francis Watts DECEMber 0522 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** AGNES BALTIMORE HOSDI TA Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 219-20-5108 Hours **Director** 1 😾 M 2 🗆 F 9, 1926 86 Yrs. Maryland Oct. show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 28a-f Maryland Baltimore Catonsville 1 Yes 2 XXIo 10e. Street and Number 10f. Zip Code ö 10g, Citizen of What Country? must be Funeral 23a permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumation." 713 Woodsdale Road 21228 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. ed Forces? Yes 2 \(\sum \) No þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Railroad Rate Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edgar Allen Francis Watts Laura Virginia Rethman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 713 Woodsdale Road, Catonsville, Maryland 21228 Lillian E. Watts/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Dec.29,2012 Glen Burnie, Maryland Glen Haven Cemetery Signature of Aneral Service Licenses 22. Name and Address of FAMBROSE FUNERAL HOME, INC. du Mo1450 1328 Sulphur Spring Rd., Arbutus, Maryalnd 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Phonician/ Atherosclerotic Cardiovascular Disease unknow. disease or condition Medical resulting in death) **Examiner** myo cardial Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the 98 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No be detached for Month Day Vear 1 Yes 2 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 S ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Division of Vital Records, P.O. Box 68760 after death. Director: After this the Hospital or Attending

24 hours a within 2

Medical

29a. Certifier

(Check

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

December 25, 2012

the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900S. Caton Avenue Baltimore, MD Wendie Williams MD

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Registrar

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 - State Registral 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2012 9:30 December Physician/ Duane Williams 4c. County of Death 4b. City, Town, or Location of Death Medical 4a. Facility Name (if not institution, give street and number) Frederick **Examiner** Frederick 2650 Mosby Court Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 07/06/1953 Social Security Number NJ **Funeral** 139-48-1161 59 1 X M 2 🗆 F Director 10d. Inside City Limits Usual Residence of Decedent 10c. City, Town or Location 1 Yes 2 XNo Frederick event, the Medical Examiner must be notified at the Maryland Director Frederick MD 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 USA ò 2650 Mosby Court Funeral 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 11. Marital Status White 1 Yes 2 XNo
If Yes, Give
Year or Dates. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 10 þ should be filed within 72 hours after 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Veterinary College (1-4 or 5+) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) Vet Tech 18. Mother's Name (First, Middle, Maiden Sumame) 12 Alice Marion Tremper Be 17. Father's Name (First, Middle, Last) Baltimore, Maryland Neville LIynn Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
771 Brighton Drive Lawrence GA 30043 19a. Informant's Name/Relationship (Type, Print) Sister Linda Williams Healy 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Glen Burnie MD 12/29/12 1 Burial 2 Tremation 3 Removal from State Atlantic Crem Fun Serv 22. Name and Address of Facility Simplicity Crem & 4 Donation 5 Other (Specify) ThomasAllenPA 7090 Ridge RD Hanover MD 21. Signature of Juneral Service Licens 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and the for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death IF FEMALE: Year 3 Ectopic pregnancy
5 Other (specify) ____ 23b. Was decedent pregnant in the past 12 months? page 2 should be detached 23e. Did tobacco use contribute to the cause of death? g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No þ To the Hospital or Attending Physician: The law requires! within 24 hours after death.
To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be ALCOHOL 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital Records, Completed 24a, Was an autopsy 2 1 No performe Yes 26. Place of Death (Check only one) 25. Was case referred to medical 4 Nursing Home 5 Residence 6 Other (Specify) Be Other: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Yes 28d. Describe how injury occurred ၉ 28c. Injury at 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Yes 2 No 5 Pending 1 Natural М 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be

Medical

 2 Medical Examiner: On the basis of
 3 Certifying Nurse Practitioner: To (Check 29b. Signature and title of certi

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Plactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BAUGHMAr, Lne Merocan no- 110

Ste 140 - MEDERICH mD

Registrar

31. Date filed (Month, Day, Year) JANO 3 2013

determined

Suicide

4 🗌 Homicide

29a. Certifier

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH C941 7/22/2013 JH State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 28 Physician/ 05:30 BM Yori 2012 Theresa Ε. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BOLTIMORE SOUNT AGNES HOSPITAL N/A Security Number **2492** 2–2494 If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours October 28,1928 Mary Land Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 🗆 Yes 2 🗓 No Anne Arundel Pasadena Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21122 8192 Forest Glen Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Siwik Schmidt Katherine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, Maryland 21122 8192 Forest Glen Dr. Joseph E. Yori (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 101/03/2013 Glen Haven Mem. Pk. Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) MOO-732 22. Name and Address of Facility McCully—Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Fureral Service Licensee 23a. Pol. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CardioPulmonary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPSIS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) DIFF DICREHER To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 | Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No Yes 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 1 Inpatient 2 잍 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of Manger of Deat 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 | Natural
2 | Accident
3 | Suicide
4 | Homicide (Month, Day, Year) iniurv 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 900 SANDERS 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2356 Michelle Zabrek December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 220-70-5738 1 🗆 M 2 🖔 F Director 54 09/27/1958 Washington, DC Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Direct Bethesda 1 Yes 2 X No Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a U.S.A. 20817 7401 Westlake Terrace, #1503 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Sales Manager Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Shirley Shor Gilbert Charles Zabrek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l 5800 Nicholson Lane, #1208, N. Bethesda, Maryland Shirley Zabrek - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once, 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 12/30/2012 Olney, Maryland 4 Donation 5 Other (Specify) MOISI 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Breast Cancer with Metastatic Disease Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine After this certificate has been signed by the attending physician and structur, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month 5 Other (specify) Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No ial or Attending Physician: The after death.
Is after death.
In Director: After this certificated in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be abrek, Michelle A Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) examilier: 1 X Yes 2 □ No 1 🖄 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital o within 24 hours aff To the Funeral Di completely filled ir Medical 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 28, 2012 071517

0 State

12/27/12

DHMH 17 Rev 06-2011

Registrar

M.D., 8600 Old Georgetown Rd., Bethesda, MD 20886

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Natalia Maria Vasquez Martinez,

31. Date filed (Month, Day, Year)

JAN 0 3 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BROSTROM December 10, 2012 DALE 10:00PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours Min. 502-14-9002 Director 86 1 X M 2 □ F May 19,1926 North Dakota Usual Residence of Deced filed within 72 hours control tall Hygiene then "naturel" or items 23e or 28e-f show ed other then "naturel" or items 23e or 28e-f show event, the Mailcal Exactiner must be natified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg 1 X Yes 2 ☐ No Maryland Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 211 Russell Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. ۾ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give 1944 Year or Dates. 1946 1 ☐ Yes 2 X No Specify: White to Completed 3 Widowed 4 Divorced 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
University Administrator (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College Be permit. Pege 1 end 2 should be fliec Department of Health end Mental Hy Importent: If item 27 is merked oth eny Injury or other from 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Peterson David G. Brostrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8039 Quarry Ridge Way, Bethesda, MD 20817 (Son) Kent D. Brostrom Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec 2012 1 🗌 Burial 2 💢 Cremation 3 💢 Removal from State Metropolitan Crem. Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licerse 22. Name and Address of Facility DeVol Funeral Home Curtis 10 East Deer Park Dr. Gaithersburg, MD 20877 (M01116)Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of)
Pneumonia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): end To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use es the burle transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Parkinsons Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🐼 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify 1 Yes 2 X No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury ² At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 06-2011

0+

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dr. Natalia Vasquez Martinez M.D.

31. Date filed (Month, Day, Year)

DEC 12 2012

D71517

8600 Old Georgetown Rd. Bethesda, MD

December 11, 2012

20814

			Pleas	e Type or	Print	in Blac	k Ind	delible Inl	k.Ensure A	All Copies	Are Le	gible.	
	_	For		State of	of Mary	land / [Depar	tment of F	Health and M	Mental Hyg	iene		
		State Registrar					Certi	ificate of L	Death	Re	eg. No. 2	012	42657
Physicia	n/	Decedent's Name	e (First, Middle, L	ast)				_		2. Date of Death Month	h	Year	3. Time of Death
Medic		Judith 1								Decembe	r 3, 2	012	8:10 PM
Examin	er	4a. Facility Name (if					- 4	4b. City, Town, o	r Location of Death		4c. Count	y of Death	1 .
	Щ	Montgome 1 5. Social Security No						Rockv:			Mon	tgome	
Funeral Director				Sex 1 □ M 2 🖾 F		yrs. last birtl	, L	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)		hplace (State or Foreign Intry)
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Mary 28a-f	rec	MD	Mon	tgomery		Sil	ver	Spring					1 ☐ Yes 2 🛣 No
a or		10e. Street and Nun						10f. Zip Code		1	0g. Citizen of	What Cou	untry?
h with	Funeral Director	1807 Aug	gust Driv	ve				209	902		USA		
deat item	Ī	11. Marital Status		12. Was Dece Armed Fo		n U.S.	13. Wa	s Decedent of H	ispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)			ican Indian,
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shouli end h is me		19a. Informant's Na				19b.	Mailing	Address (Street	and Number or Run	al Route Number,	City or Town,	State, Zip	Code)
nd 2 saith n 27 er tn		Kevin C.	Buckhold	t/Son		18	307 <i>A</i>	August D	rive, Si	lver Spri	no. MT	200	0 2
of H.		20a. Method of Disp	oosition Cremation 3	Demoust from	20	Ob. Place of	Disposit	tion (Name of tory or other place		Date	20c. Location		
Page ment ant: ury o		4 Donation	5 Other (Spec	∟ н emovai πom cify)	Ve We	esley	Char	pel Ceme	tery Dec	2. 8, 2012 F	Rock H	la11.	MD
permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show eny injury or other traumetic event, the Medical Examiner must be routified at once.		21. Signature of Fur	neral Service Lice	nsee	^				ss of Facility ins	Funeral	Home T	no	TID
20599			anna	90	Jellon		Poo	univers	sity Blvd	. W. Si	lver S	nc. nrinc	, MD 20901
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certif nding use e	⋛	IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, out							334 D	ate of deli	ven/
eeth d for	흥	in the past 12 r		4 🖳 Preg	nant at time	Fetal death of death		Ectopic pregnand Other (specify)	у			onth	Day Year
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or A after Direc	Certificate:	4 D Homicide	determine	d 28e. Place buildi	of Injury - Ang, etc. (Sp	At home, far ec <i>ify)</i>	m, street	t, factory, office		28f. Location (Str. City or Town,		er or Rura	al Route Number,
spital ours erai filled	edical	29a. Certifier 1	Certifying Ph	vsician: To the h	eet of my k	nowlodgo d	loath one	aurod at the time	e, date and place, a				
To the Hospital or Attending Physician: The lew requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate hes been signed by the ettending physic completely filled in by the funeral director, page 2 should be detached for use as the breather the funeral director, page 2 should be detached for use as the breather the funeral director, page 2 should be detached for use as the breather the funeral director, page 2 should be detached for use as the breather the funeral director.	<u>ed</u>	(Check 2	Medical Exar	niner: On the bas	sis of examir	nation and/or	investiga	ation, in my opinic	e, date and place, a on, death occurred a he time, date and pl	t the time date and	Inlace and du	ie to the co	ause/s) and manner stated
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Registra	r		.U U O 20	16 Ck	was	B. x	back						

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			For St	ate of Maryland	d / Depa	rtment of He	ealth and M	lental Hyg	ene	1.0	10050
		_1	State Registrar		Cen	tificate of De	eath	Re	eg. No.Z U	12	42658
	Physicia		Decedent's Name (First, Middle, Last)					Date of Deatl Month		Year	3. Time of Death
	Medic	al .	Charles E. Brown					Novembe:	T		5:30 p ^M
	Examin	er	ia. Facility Name (if not institution, give street Holy Cross Hospital	and number)		4b. City, Town, or L Silver S			4c. County Mont	gomer	y
	Funeral		i. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		g. Birthpl	ace (State or Foreign
	Director		289-22-1157 1 ∑ M	2□F 85	Yrs.	Months Days	Hours Min.	(Month, Day, Aug. 12		Ohio	(9)
	oow at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10	Od. Inside City Limits
	arylar ta-fst ified	Director	MD P.G	. S:	llver S	Spring					1 ☐ Yes 2 ☒No
	the M or 28 e not	₫	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	What Count	try?
	s 23a	Funeral	3152 Gracefield Ro	ad, MS 424		20904			USA		
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36	after al", or Exami	d by	1 4	Pres 2 □ No Yes, Give Year or Dates. 1945 – 4	46 1	☐ Yes 2 🖾 No	Specify:		Specify:	White	
Ğ	within 72 hours after death with the Maryland glene et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's Educati (Specify only highest grade co	on	16a, Deced	ent's Usual Occupat	tion uring most of work	ina	16b. Kind of B	usiness/Inc	lustry
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy hurry or other traumatic event, the Medical Examiner must be notified at. and house.		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ Rem	oval from State	emetery, cren	sition (Name of natory or other place		ec. 6, 2012	20c. Location	•	
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Ba	Depar Impol any Ir		21. Signature of Fulleral Service Licensee	Jack	Fr	Name and Address ancis J.	Collins	Funeral	Home In	nc. oring	. MD 20901
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Division of Vital Records,	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	 Place of Injury - At he building, etc. (Specif. 		reet, factory, office		28f. Location (S City or Tow		ber or Rura	l Route Number,
۵	ours a	cal	29a. Certifier 1 A Certifying Physician	n: To the best of my knov	vledge, death	occurred at the time	e, date and place,	and due to the ca	use(s) and mar	nner as stat	ed.
	To the Hospital or Attending Physician: The law requires that the death certificate t within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse Pr	On the basis of examination	on and/or inves	stigation, in my opinio	on, death occurred	at the time, date a	nd place, and d	ue to the ca	iuse(s) and manner stated
	within to the state of the stat		29b. Signature and the certifier		5	29c. License			29d. Date sign		
	12+1		/ metall	lew	700		4093		Novemb	er 30	, 2012
			30. Name and address of person who comp Mark Parkhurst, MD	eleted cause of death (Iter 3110 Grac	п 23a) (Туре, .efield	Print) Road, Si	.lver Spr	ing, MD	20904		
	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Sign							
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthp	place (State or Foreign
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	or 28,	Ē	MD Montgomery 10e. Street and Number		KOCKVI	10f. Zip Code		1	0g. Citizen of	What Cour	ntry?
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Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature ← Funeral Service Licensee	ПОТ		2. Name and Address					116, 110
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Ä	n: The fficate or, pag		25. Was case referred to me ical	of rich,	dery	26. P	lace of Death,(Chec	1 Yes	2 L3 No	T Tes	2 L NO
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of	ig Phy ter this		27. Manner of Death 1 Natural 5 Pending	a. Date of injury (Month, Day, Year)	28b. Time o		y at k?	28d. Describe h	ow injury occu	rred	
on	eath. or: Aff	fica	2 Accident Investigation				Yes 2 No				10
visi	or Att	Certificate:	4 Homicide determined	e. Place of Injury - At h building, etc. (Specit	ome, farm, st fy)	reet, factory, office		28f. Location (S City or Tow		ber of Hura	al Route Number,
Ö	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transit		29a. Certifier 1 Certifying Physician:	To the best of my know	vledge, death	occured at the time	e, date and place. a	Ind due to the cau	use(s) and man	ner as stat	ted.
	e Hos 124 h e Fun	Medical	(Check 2 Medical Examiner: Or only one) 3 Certifying Nurse Prac	the basis of examination	on and/or inve	stigation in my opini	on, death occurred	at the time, date a	nd place, and d	lue to the c	ause(s) and manner stateu.
	withir to the some	2	29b. Signature and title of certifier		0	29c. Licens			29d. Date sign		
	5		1 N. Robert Bis	schlor	luss	, 100	4115		Deces	whe	23,2012
			30, Name and address of person who complet		m 23a) (Type,	Print) 20	RUSS	ELL 1	Wer	UE	12/77
			1 Deta floor Month Day Year)	/32. Registrar's Signa	eture	Pa	(HER	520LR	4 nu	200	00.1/
	Sta Registi		31. Date filed (Parth, Day, Year) 2012	oz. negistrar s olgni		رام					

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State of Maryland / Department of Health and Mental Hygiene

December Section Sec			1	For State Registrar	State of Mary		tificate of D		remairiye F	Reg. No. 20	12	42660
## Country Description Security Funds Security Fund		Physicia	n/	1. Decedent's Name (First, Middle, Last,					2. Date of Dea	th		
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Second Second Number Secon		Examin	er									er
216-30-0906 18 M 2 F 78 78 78 78 78 78 78		Funeral		5. Social Security Number 6. Set	7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Year)	9. Birthp	place (State or Foreign try)
The control of the		Director			М м2□F 78	3 Yrs.					Vir	ginia
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LOCA Henry Balley Salisy		Maryl 28a-f otifie	irec		er	Snow H						
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The part of the	Man	d 2 shoul alth and I n 27 is m er trauma				19b. Mailin 3802	ng Address (Street a Algonqui	end Number or Run on Trail	al Route Number Snow E	City or Town, S Iill, MD	State, Zip (2186	Code) 53
Segmentally list conditions, and cause from death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock, or heart failure. List only one cause on spiratory arrest, shock or heart failure. List only one cause on spiratory arrest, shock or heart failure. List only one cause on spiratory arrest, shock or heart failure. List only one cause on spiratory arrest, shock or heart failure. List only one cause on spiratory arrest, and shock or heart failure. List only one cause on spiratory arrest, and shock or heart failure. List only one cause on spiratory arrest, and shock or heart failure. List only one cause on spiratory arrest, and shock or heart failure. List only one cause on spiratory arrest, and	more	Page 1 an nent of He int: If iten iny or oth		1 Burial 2 Decremation 3 D	Removal from State	cemetery, cren	natory or other place	e)	Į.		-	
St. Spir.1 Lenter the deledace, or complexationer that cause if the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Battween Onset and Death Three deledace, or heart failure, List only one cause on seth line. Try storior Medical Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or condition resulting in death) Three deledace Cause (Final disease or conditions) Three deledace C	Balti	permit. I Departri Importa any inju	Ν			22	Name and Addres	s of Facility Funeral H	lome Pro	fession	al As	sociation
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autopsy performed?/ 1 yes 2 No No	9	cate b			d							
autopsy performed?/ 1 yes 2 No No	Box 68	e death certif the attending hed for use a	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3		ey .				*
autopsy performed?/ 1 yes 2 No No	, 0.	ss that the igned by be detac	ğ			ot resulting in the u	ınderlying cause giv	ven in Part I.				/
autopsy performed?/ 1 yes 2 No No	ords	requir been s should	etec									
25. Was case referred to medical examiner?	Reco	The law ate has page 2	Comp						autor perfo	rmed?/	prior to co death?	empletion of cause of
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29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)		Hospita 24 hours Funeral	ledical	(Check 2 Medical Exami	ner: Dn the basis of exam	ination and/or inves	tigation, in my opinio	on, death occurred	at the time, date a	ind place, and di	ue to the ca	use(s) and manner stated.
State State Begistrar State 31. Date filed (Mgrith_Day, Year) 2012 32 Registrar State Begistrar		To the To the Complex	2				20o License	a number		20d Data sign	nd (Month	Day Year
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DMCW M. WOW, MD 400 Earther Show Show Show, Sakrabuky, MW 21804 State Begistrar 31. Date filed (Marith Pay, Year) 2012 32 Registrar's Signature Sakrabuky		Α		Sunald M	· Covo, M.)	0001	10688		12/10	101	2
State State 31. Date filed (Mgrith, Day, Year) 2012 32 Registrar's Signature		5,70		30. Name and address of person who o	completed cause of death	(Item 23a) (Type, F	Print)	ShruF	SACISBO	KY, MU	1210	804
				31. Date filed (Month, Day, Year) 20	12 32/Registrar's	Signature	enter					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 42661 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Mary Brittingham December 13, 2012 0400 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Rehabilitation & Nursing Ctr Wicomic Salisburg 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months (Month, Day, Year) 220-16-9512 Director 1 M 2 X F 02/21/1925 Maryland Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b. Count Page 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits by Funeral Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA East Gate Village, Apt. 503 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify If Yes, Give White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Seamstress Clothing Manufacturing 27 is marked other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ည Laura Vickers Kenneth Massey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 item 27 other tra Dorothy A. LaCurts/Daughter 35588 Tingle Rd., Willards, MD 21874 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 12/14/2012 Salisbury, MD Salisbury Crematory 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition Onset and Death Physician/ 1013 Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the usual requires that the Change of the death.

Within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Brittingham in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 16 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🛣 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

GREGORIO

DHMH 17 Rev 06-201

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5302

12-13-12

CHINABERRY DR., SALISBURY, MD 21801

Belleza

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. BELLOSO

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	R	For State		<i>Ce</i>	ertifica	ate of D	eatn ———		- 1	2. Date of De	Reg. No			3. Time of Deal	-
Physician Iedical Examine	er	Decedent's Name (First, Middle George Jeron	ne Butl			-1				Month Decemb	er 22,			0238 hrs	
	4	a. Facility Name (if not institution Saint Mary's Hospital	n, give street and	number)			city, Town, o eonardtov	vn				St. Mary's	\$		
Funeral Director		Social Security Number 215 35 7129	6. Sex	7. Age (In yrs.	last birth		Under 1 Ye		er 24Hrs. Min.	8. Date of I			Foreign	place (State or ntry) MD	
215-0036 be filed within 72 hour natal Hygiene. rked other than "naturent, the Medical Examples And Commission Head	lo be completed by Funeral Director	0e. Street and Number 45693 Oregor 1. Marital Status 1. Never Married 2 Ma	12. Was I Armed 1 Ye orced If Yes, Give cify only highest g College Last) me But 1 hip (Type, Print) r , Sr . / F	Decedent Ever in the Forces? S 2 X No Year grade completed) e (1-4 or 5+) Ler, Sr Father 20th	exir.	13. Was De If Yes, s 1 Yes Decedent's Library Maint Maint Maint Decedent's Library Maint Decedent's Library Maint Maint 22. Name	2065 eccedent of H specify Cuba s 2 N Jsual Occupation Working life enance dress (Stree Orego (Name of cubace) emanded emanded em. Ce	ispanic Origin, Mexican o specify: ation (Give e. DO NOT CE 18.Mother Car eet and Nun on Wa emetery, ess of Facility	kind of wire retired to the control of winder or River Legister 12/:	(First, Middle Smi	US No- 16b. P P th Jumber, TOn 20c Lee	14. Race - White, Specify: Exind of Businesurname) City or Town Park Location - Conard	Americ etc. 31ac Siness/In Comparison State, State, MI Comparison State Siness/In Sin	an Indian, Black Ck dustry Zip Code) D 2065 Town, State wn, MD Cal Ho	□No sk,
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Division of Vital Records, spittal or Attending Physician: The law requiremental birector. After this certificate has been signal and a first this certificate has been signal birector. After this certificate birector and birector has been signal or the funeral director page 2 should be a first the control of the first think the former of the birector base 2 should be a first think the first thin	edical Certification: To Be Completed	3 Suicide 6 Coul 4 Homicide 29a. Certifier 1 Certifying P.	Hospital: 1 ding stigation ld not be immined 28e. F (Spection 1995) (Spection	utpatient 3 Time of Injur arm, street, f ath occurred investigation	DOA y 28c. In 1 actory, office I at the time, , in my opinic	yes 2 building, edate and plon, death on the number	Nursin: k? No etc.	per year year year year year year year ye	Resident (Street n., State) ause(s) ate and	no 1 dence 6 injury occurre t and Number and manner place, and de	other: Other: as state ue to the	ral Route Numb	ause of		
	-	30. Name and address of person	who completed	cause of death (It	em 23a)			C.M.E.				ecember	۷۷, ۷۷		_

State Registrar

parker

Assistant Medical Examiner

Ana Rubio M.D., Ph. D.

31. Date filed (Month Cay, 2012

900 W. Baltimore Street, Baltimore, MD 21223

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Ma	aryland	-				lental Hy	giene			
			State Registrar			Cer	tificate d	of Dea	ath		Reg. No	<u> 20</u>	12	42663
	Physicia	ın/	Decedent's Name (First, Middle, Las	t)						2. Date of De Month	ath Da	av	Year	3. Time of Death
	Medic	al	Ruthie Lee Book							12		<u>(2</u>	2012	4:44 cm
	Examin	er	4a. Facility Name (if not institution, give	•			_		ation of Death			County o		
Mary Company	Funeral		18003 Mateny Road 5. Social Security Number 6. Se		e (In yrs. las	st birthday)	Germa If Under 1		1 Jnder 24 Hrs.	8. Date of Bir		lontg	omery	ace (State or Foreign
	Director		430-74-7306	□ M 2 🛱 F	$\sigma \sigma$	Yrs.	Months D		ours Min.	(Month, Da	y, Year)		Countr	
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တ္က	", or i	ρ	1 Never Married 2 Married	Armed Forces? 1 Yes 2 If Yes, Give	No		Yes, specify Yes 2		exican, Puerto	Rican, etc.)			k, White, et	
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212	within /2 hours after death with the Maryland gjene. et than "natural", or items 23a or 28a-f sho the Me≝ical Examiner must be notified at		Elementary/Secondary (0-12)	2 years	+)	Nurse		irea)			Pri	ivate		
P 3	be filed ental Hyy rked oth ic event	Be	17. Father's Name (First, Middle, Last)					18.	Mother's Nam	e (First, Middle,	Maiden	Surname))	
Sa Sa	Ment Ment narke natic e	욘	Briscoe Jackson					Ne	ettie W	illiams				
Mar	2 should th and Me 27 Is mar traumati		19a. Informant's Name/Relationship (Ty							al Route Numbe				
e i	Healt Healt Hem 2		Robert Booker/Hus 20a. Method of Disposition	Danu	20h Pla		Maten sition (Name o			212 Ger				
Baltimore, Maryland 21215-0036	permit. Fage 1 and 2 should be hied within 72 hours after death with the Maryland brackment of Health and Mental Hygiene. Inpartment of Health and Mental Hygiene. Inpartment if them 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Donation 5 ☐ Other (Specify	Removal from State	cei	metery, crem	atory or other	place)		Date			City or Tow	
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Box 68760	been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 pronths? 1 ☐ Yes 2 Д No	23c. If yes, outcome of 1 ☐ Live Birth 4 ☐ Pregnant at	2 🗌 Fetal	death 3	Ectopic preg	nancy				23d. Date Mon	e of deliver	y Day Year
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cords, P.O.	ned b	Y P	Part II. Other significant conditions co	ntributing to death be	ut not resul	lting in the ur	nderlying caus	e given in	Part I.	23e. Did to	obacco u	use contril	bute to the	cause of death?
JS,	an sign	edt			_					1 🗆	Yes 2	□ No :	3 🗆 Proba	ably 4 Unknown
	as bee	Completed by								24a. Was		24b. W	ere autops	sy findings available pletion of cause of
9	ate h	Som								autop perfo	med?	de	eath?	LANCE OF THE PARTY
<u> </u>	ertific ector,	Be (25. Was case referred to medical examiner?	1 2 1			2	6. Place o	f Death (Check					
F Y	this o	요	1 ☐ Yes 2 😾 No			R/Outpatien				me 5X Resid				
C =	h. After funer	Certificate:	1 Natural 5 Pending	28a. Date of injur (Month, Day	Year)	8b. Time of injury		Injury at work? 1 🔲 Yes		28d. Describe h	ow injur	y occurred	d	
SIO	r deal	rtifi	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		ry - At hom	ne, farm, stre				28f. Location (S	Street an	d Number	r or Bural F	Route Number
DIVISION Of VITAL RECORDS,	s afte		4 - Hornicide determined	building, etc	(Specify)					City or Tow			or riara.	cata rumbon,
iosof	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phys (Check 2 Medical Examir	ician: To the best of o	ny knowlec amination a	dge, death o	ccurred at the	time, date	e and place, ar	nd due to the ca	ause(s) a	nd manne	er as stated	i. se(s) and manner stated.
t e	thin 2 the 1 mple1	Μe	only one 3 Certifying Nurs 29b. Signature and title of certifier	e Practitioner: To the	best of my	knowledge,	deeth populin	5 at the fire	ns, date and pla	ne, and due to t	he cause	e(s) and the	armor as etc	stad.
٩	. ≱ . 5		290. Signature and title of certifier with the control of the certifier with the certifie	Wan	9 ,	M.D	1	ense num				_	(Month, De	ıy, Year)
	65M		30. Name and address of person who co		/		יטען	6382	0		12	/12/2	2012	
	. 7%/		Dongmei Wang, MD	9715 Medi				35	Rockvil	lle, MD	208	50		
	Stat	-	31. Date file (Pay, 4 ear) 12	32. Registra	r's Signatur	re L	,		No. of the last					
	Registra	ir	THE M THE PAIR	remain	P.	park				<u> </u>				

DHMH 17 Rev 06-2011

		30. Name and address of person who completed cause of VOHICA	of death (Item 23		3199	12	110/12	10 0 Col
within 24 hou To the Funer completed fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best Medical Examiner: On the basis of Certifying Nurse Practioner: To the 29b. Signature and title officertifier	of examination and the best of my kn	nd/or investigation, in my on nowledge, death occurred 29c. Lic	pinion, death occurred at at the time, date and place ense number	t the time, date and place, and due to the cause	ace, and due to the case(s) and manner as s Date signed (Month,	ause(s) and manner st stated. Day, Year)
within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of I	Day, Year)	injury	vork?	28d. Describe how in 28f. Location (Street City or Town, Sta	and Number or Rura	al Route Number,
- <u>S</u>	To B	examiner? 1 Yes No Hospital:		R/Outpatient 3 DOA	6. Place of Death (Check Other: 4 \(\sum \) Nursing Ho	k o <i>nly</i> o <i>ne)</i> ome 5 🗆 Residence	Other (Specif	n Hashi
certificate has been si irector, page 2 should	• Completed	25. Was case referred to medical			S Plane of Park. Oh	24a. Was an autopsy performed 1 Yes	prior to or death?	opsy findings availab ompletion of cause of
D a	þ	Part II. Other significant conditions contributing to death	h but not resulti	ing in the underlying caus	e given in Part I.		2 No 3 Pro	
ied by the attending phy detached for use as the	Physician/Medic		th 2 🗌 Fetal de nt at time of dear	leath 3 Dectopic preg			23d. Date of delin	very Day Year
attending physician and for use as the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or impury that initiated events c.	as a consequend					
midian/ Medical caminer		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Due to (or a	sed the death. L line. as a consequence		dying, such as cardiac o	or respiratory arrest,		Approximate Interval Between Onset and Death
Depar Impor any in		21. Signature of Furreral Service Licensee	nl	1501 Snow	Funeral F Hill Rd, S	Salisbury,	ssional A MD 21804	
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show my injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	ate cem	ce of Disposition (Name on tetery, crematory or other .sbury Crema	tory 12/1	.2/2012 S	alisbury,	MD
lealth and em 27 is m her traum		19a. Informant's Name/Relationship (Type, Print) Lisa K. Cullen/Daughter	1		urleys Necl	k Rd., Mar	dela Spri	.ngs, MD 2
Mental Hy arked ott atic even	To Be	17. Father's Name (First, Middle, Last) Raymond w. Dial				e (First, Middle, Maide ed K. Webb	,	
giene. ner than t, the Me		Elementary/Seconday (0-12) College (1-4 o		ife. DO NOT use reti Customer Ser	red)		Telephon	ie
"natural edical Ex	Completed	3 Widowed 4 Divorced Fear or Dates 15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Od (Give kind of work do	cupation ne during most of worki	ing 16b	o. Kind of Business In	nite ndustry
", or item aminer n	ا۾	11. Marital Status 1 □ Never Married 2 ▼ Married 12. Was Deceder Armed Forces 1 □ Yes 2 □ If Yes, Give	s?	13. Was Decedent If Yes, specify (1 ☐ Yes 2 ▼	of Hispanic Origin? (Specuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	etc.
s 23a or ust be n	Funeral Di	10e. Street and Number 23439 E. Hurleys Neck Ro	oad	10f. Zip Co-		10g.	Citizen of What Cou	intry?
28a-f sho otified a	Director	Maryland Wicomico		Town or Location dela Springs				10d. Inside City Lin
Funeral Director		5. Social Security Number	Age (In yrs. last)	Yrs. Months Da	ys Hours Min.	8. Date of Birth (Month, Day, Yea, 02/05/195	r) Cou	nany
Examir		4a. Facility Name (if not institution, give street and number	Lake	Sa	is bury ear If Under 24 Mrs.		4c. County of Death	ico
Physicia Medio	al	Julie K. Cullen					Day Year	3. Time of Deat
_		State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	t Death		No.2012	4266

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RUDY DUMA 2012 DEC 12:04A Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WILSON HEALTH CARE CENTER GAITHERSBURG Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Months Hours Min. 0871371937 ROMANIA 75 558-79-7683 **Director** Usual Residence of Decedent shov 10a. State 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 28a-f 1 ☐ Yes 2 ☑ No MONTGOMERY CLARKSBURG MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 26304 FOREST VISTA DRIVE 20871 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cyban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No Specify Specify: WHITE Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than RETIREMENT COMMUNITY Elementary/Seconday (0-12) College (1-4 or 5+) SENIOR MECHANIC other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ION DUMA CONSTANTINA FIREA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20871 19a. Informant's Name/Relationship (Type, Print) 26304 FOREST VISTA DR., CLARKSBURG, item 27 MARIANA DUMA / SPOUSE 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot STAUFFER CREMATORY 12/11/20 2 FREDERICK. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / un ral / ice Licensee 22. Name and Address of Facility P.O. BOX 86 HILTON FUNERAL HOME BARNESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Betw shock, or heart failure. List only one cause on each line Immediate Cause (Final Sinset and Death Physician. Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes or Attending Physician: \alpha after death. 25. Was case referred to medical examiner?

1 Yes 2 No Be funeral director, 26. Place of Death (Check only one) é Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination afford investigation, if my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 204/15 H. Kollen Der December 10,2012

State Registrar

DHMH 17 Rev 7/2009

Registrar UEU I

31. Date filed (Month, Day, Year)

Registrar's Signature

M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT BIRSCHBALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dean 2012 3:00 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 30583 Olde Fruitland Road Wicomico <u>Salisbury</u> Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days 1 X M 2 □ F Months Min. Hours 2-5-1928 Maryland Director 213-24-2337 84 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 30583 Olde Fruitland Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1

Yes 2 □ No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married 1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No 3 Divorced 4 Divorced Year or Dates 1947 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 District Manager Electric Company permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Brice Dean Mary Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30583 Olde Fruitland Road, Salisbury, MD 21804 Shirley Dean - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crematory of Delmarva 12-11-2012 Delmar, Delaware 21. Signature of Fureral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. It 1. Enter the dise se cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. shock, or heart failure. List on nterval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, assuing to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Yes 2 No ed by the 9 Unknown P.O. s teen signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ he law requires Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform te 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to predical **Division of Vital** director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this d in by the funeral d 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) To the Hospital or within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 12 death (Item 23a) (Type, Print) IVA State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^M12/08/2012 JOSEPHINE CAULK DAWSON 8:28P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TALBOT HOSPICE HOUSE **EASTON TALBOT** 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours (Month, Day, Year) Director 215-20-4930 1 🗆 M 2 🕻 F 86 01/31/1926 BOZMAN, MD or than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT TRAPPE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28266 ISLAND CREEK RD. 21673 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) TEACHER PUBLIC SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file n end Mental I is marked of မှ JOHN KERSEY CAULK, JR. LENA MATILDA LAMDIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health e : if item 27 is JAMES C. DAWSON / SON 28266 ISLAND CREEK RD. TRAPPE, MD 21673 20a. Method of Disposition 20c. Location - City or Town, State CHERNAL EAR BOY GROMATION permit. Page 1
Department of
important: if it 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CENTER 12/11/2012 | STEVENSVILLE, MD 21. Signatury of Furey Pervice Licens FELEDOWSANDHER FENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sach line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications the Immediate Cause (Final disease or condition Priysician AIKIN IONI disease Medical resulting in death) Examiner emen7 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ettending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be 24 hours after death. • Funeral Director: After this certificate has been siq etely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 \ No 잍 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1/Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7115/132 12/0-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 598 CYNWOOD DRIVE, STE. 104, EASTON, MD 21601 JORGE H. ABREGO, MD

State Registrar 32. Febristrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42668 State of Maryland / Department of Health and Mental Hygiene 2 1 2 State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ BUFORD DENNIS DEC 2012 9:55 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges College Park 5123 Niagara Pl. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Months Director 1 🔀 M 2 🗆 F 414-56-7710 Yrs. Mar. 23, 1936 TN 76 Usual Residence of Decede or then "netural", or items 23e or 28a-f show the Wedloal Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland Director 1 Yes 2 X No College Park Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 USA 5123 Niagara Pl. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married ۾ 3altimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖾 No Specify: If Yes, Give 1957 Year or Dates. 3 Widowed 4 Divorced Completed **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) PG Board of Education Special Education Dept. Head injury or other treumetic event, Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Importent: If Item 27 is marked oth eny injury or other treumetic event ones. 17. Father's Name (First, Middle, Last) ၉ Roberta Paschall Dorris Buford Dennis SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5123 Niagara Pl. College Park, MD 20740-1151 Sylvia Dennis - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Veterans Cemetery 12-26-2012 Cheltenham, MD 4 Donation 5 Other (Specify) MD Signature of Funeral Service Licensee 22. Name and Address of Facility.
Marshall-March Funeral Home of Maryland eclarine Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatic Encephalopathy disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Metastatic Lung Cancer Sequentially list conditions, Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-trensit or Attending Physicien: The lew requires thet the deeth certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the § only one) 29b. Signature ar Atitle of certifie St1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912 7701 Carroll Ave. Takoma Park, MD Nasreen Mustafa Kango, MD31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 10 2 = .

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42669 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2012 Year Physician/ Michael Frederick Eisert December 5:56 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomerv 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Director 186-36-7570 1 X M 2 D F 67 June 23. 1945 PA iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 Yes 2X No MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 9617 Dilston Road 20903 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: "natural", If Yes, Give Year or Dates. 1966-73 Specify:White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Administrative Office Elementary/Secondary (0-12) College (1-4 or 5+) Senior Systems Accountant of US Courts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ge 1 and 2 should be filed at of Health and Mental H If item 27 is marked ot Jerome Michael Eisert Winifred Bessie Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carole Ann Eisert/Wife 9617 Dilston Road, Silver Spring, MD 20903 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Page 1 a permit. Page 1
Department of
Important: If it
any injury or o Dec. 10, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 Rockville, MD 21. Signature of Fitneral Service Licensee 22 Name and Address of Facility rancis J. Collins Funeral Home Inc. 500 University Blvd. W. . Silver MD 20001 23a. Part 1. Enter the disease, or complications that caused the chath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of): Examiner Amyotrophic Lateral Sclerosis (ALS) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (ur as a consequence of): , attending physician and dor use as the burlal-transit Cause (Disease or injury Physician: The law requires that the death certificate be executed Cardiopulmonary Arrest that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 4 Pregnant at time of death been signed by the a should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law rawin 24 hours after death.

To the Funeral Director: After this certificate has the completely filled in by the funeral director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔯 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State

10+1

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Registrar

29b. Signature and title of cert

Sami Mourad, MD

31. Date filed (Month, Day, Year) DEC 05 2012

address of person who completed cause of death (Item 23a) (Type, Print)

1500 Forest Glen Road,

Registrar's Signature

29c. License number

D70793

Silver Spring,MD 20903

29d. Date signed (Month, Day, Year)

December 3, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2012 Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Everett Mary Margaret 6:01 Medical December <u> 2012</u> 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico 601 Tressler Drive Salisbury 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 220-12-6833 1 □ M 2 🔀 F 86 01/08/1926 Maryland 27 is marked other then "netural", or items 23e or 28a-f show treumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other then "netural", or items 23e or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 601 Tressler Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🏝 No
If Yes, Give 1 Never Married 2 K Married Black, White, etc. Completed by 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Shipping Co. Receptionist/Telephone operator Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Walter F. Humphreys Elizabeth (unknown) Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 eny Injury or other tr once. George G. Everett/Husband 601 Tressler Dr., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 ☐ Other (Specify) 12/11/2012 Salisbury Crematory Salisbury, MD of Funeral Signatur Name and Address of Facility Home Professional Association 0 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the buriel-transi the Hospital or Attending Physician: The law requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 mo Day Year 1 Yes 2 No ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Yes Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform certificate 1 🗌 Yes 1 Yes Director: After this certific d in by the funeral director, B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: |은 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Dath 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and place and place and place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of death (Item 23a) (Type, Print)

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Registrar

2 2012

			Please Type or				-	_	e.
		•	For State O	f Maryland / Depa Cer	artment of F tificate of L			giene Reg. No2	2 1.2671
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ith	3. Time of Death
	Medic	al	ROSALIND BLADES EASON 4a. Facility Name (if not institution, give street and num	lher)	4b City Town o	r Location of Death	DECEMBE	R 9, 2012 4c. County of D	
· mari	Examin	er	27813 OXFORD ROAD	501)		(FORD		TALBO	
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2 【X F	7. Age (In yrs. last birthday) 73 Yrs	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day		Birthplace (State or Foreign Country)
			Usual Residence of Decedent				JULY 3	0, 1939	MARYLAND
	aryland a-fsh	Director	10a. State 10b. County TALBOT	10c. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Ë	10e. Street and Number		10f. Zip Code	CEA		10g. Citizen of What	Country?
	ath with	Funeral	27813 OXFORD ROAD 11. Marital Status 12. Was Dece	dent Ever in U.S. 13. V	1	654 ispanic Origin? (Spe	cify Yes or No-	USA	merican Indian,
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Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) WILLIAM LEE EASON, HUSE			and Number or Rura.		; City or Town, State, MD 21654	Zip Code)
ď.	of Hea of Hea of Hea of Hea r other		20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from	20b. Place of Dispo	,	!	Date	20c. Location - City	or Town, State
Baltimore,	permit. Page 1 a Department of I Important: If its any injury or of		4 ☐ Donation 5 ☐ Other (Specify)	JUNIOR O	RDER CEME	TERY 12/1		PRESTON,	
Bal	Departicular Department on in concession on		21. Signature of Earl Pay Pervice Licensice	DES DE	ELLOWS Addre	IEĽFENBEIN Harrison	STREET.	IAM FUNERA EASTON.	L HOME, P.A. MD 21601
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Zit.	hysici his cer al direc	မူ		Inpatient 2 ER/Outpatier	it 3 ☐ DOA Oth	er: 4 Nursing Ho	me_5 Resid	ence 6 Other (Sp	pecify)
n of	nding P ath. : After t e funera	cate:	27. Manner of Death 1 Natural 5 Pending (Mont) 2 Accident Investigation	of injury 28b. Time of injury injury	work	yat (? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be exwirtin: 24 buru's after death. within 24 buru's after death. To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria	Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, streng, etc. (Specify)	eet, factory, office		28f. Location (S City or Town	treet and Number or n, State)	Rural Route Number,
u	Hospita 24 hours Funeral stely fille	Medical	29a. Certifier 1 Certifying Physician: To the b 2 Medical Examiner: On the bas	is of examination and/or invest	igation, in my opinio	on, death occurred at	the time, date ar	nd place, and due to t	he cause(s) and manner stated.
	To the within to the comple	Ž	only one) 3 ☐ Certifying Nurse Practitioner 29b. Signature and title of certifier	: To the best of my knowledge,	death occurred at t 29c. License			ne cause(s) and manne 29d. Date signed (Mo	
			1/4 by Sul	\ W	D4-	1232		12/1	0/2012
	PS L		30 Name and address of person who completed caus	e of death (Item 23a) (Type, F	Print)	11 1	Eastu	D440	211-01
	Stat	e	31. Date filed Month 12 7472 2012 32.	nistrar's Signature	ares	10 tope	~ a >To	1, 1,44)	11001

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend 23a & Pt III per med cert 6936 2713/13 Popies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carolyn Warren Foltz 0550A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . GENINSULA RABIONAL SOLISHIN HICOMICO . Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 1 □ M 2 🗓 F 216-38-7592 12-8-1942 Marvland Usual Residence of Decede or 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1127 Riverside Drive 21801 USA within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. ٤ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of and 2 should be fill of Health and Mental item 27 is marked of 2 Warren Myrtle Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Foltz - Husband 1127 Riverside Drive, Salisbury, Maryland 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Siloam Cemetery 12-19-2012 Siloam, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Par 1. Enter the disease, or complication shock, or heart fallure. List only one of the street is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. Immediate Cause (Final Physician/ Onset and Death Coronary artery disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transIt or Attending Physician: The law requires that the death certificate be executed Pulmonary hypertension Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year Yes 2 No been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag DULINDA ARM 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Hedical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALISBURY State Registrar's Signatu Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RAJ GUPTA Month Year 08 2012 1:01 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. **Director** 1 🛣 M 2 🗆 F NONE 74 MAY 3, 1938 INDIA or 28a-f show with the Maryland 10a. State 10b. County must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No PRINCE GEORGES GLENN DALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12203 JAMES MADISON LN. 20769 INDIA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian , or à 1 Never Married 2 XMarried ☐ Yes 2 🛣 No f Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: ASIAN INDIAN "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation iit. Page 1 and 2 should be filed within 72 nr artment of Health and Mental Hygiene. artment of teem 27 is marked other than "in cortant: if item 27 is marked other than "in cortant." 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 MANUFACTURING SELF EMPLOYED Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KULWANT RAI **GUPTA** VIDHYA BATI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KULDEEP GUPTA/SON 12203 JAMES MADISON LN., GLENN DALE, MD. 20769 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ott 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12/15/12 CHAMBERS CREMATORY RIVERDALE, MD. Signature of Funeral Service Licenses 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Myocardial Intarction Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of cause. Enter Underlying 3 Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 4 Pregnant 9 Unknown 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💢 No Other: ပ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred

Box 68760 P.O. Division of Vital Records, funeral director, To the Hospital or Attending within 24 hours I fter death. 24 hours fter death. Funeral Director A completely filled in by th∈

(Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number erd Beck, top 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print)

Stord Bech, MD 2003 Medical Parkway, and polis, MD 21401

State Registrar

Medical

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42674 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month William Richard Herndon December 11:52 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 577-32-0163 Director 85 1 ፟ M 2 □ F May 6, 1927 Washington, DC 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 1 and 2 should be filed within 72 hours after death with the fi Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or other traumatic event, the Medical Examinar must be a 10g. Citizen of What Country? Funeral 9424 Curran Road 20901 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. ۾ 1 Never Mamed 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: Black Completed 3 🗌 Widowed 4 🗆 Divorced it res, Give Year or Dates.1951-57 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Writer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Herndon, Sr. Lucia Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 9424 Curran Road, Silver Spring, MD 20901 Marilyn A. Herndon/Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Dec. 7, 2012, permit. Page Department of Important: If any injury or once. 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Lincoin Memorial 4 Donation 5 Other (Specify) Suitland, MD Cemetery 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death D not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Dementia, Cerebrovascular Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): atti ...
e attending physician end death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?

1 Yes 2 No Month Year Day signed by the a 9 Unknown P.O. Hospital or Attending Physician: The law requires that the 24 hours after death. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I performe After this certificate 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 2 🖾 No မ 1 Yes 1 Inpatient 2X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 X Natural 5 Pending injury 2 Accident 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of confifier 29c. License number 29d. Date signed (Month, Day, Year) D56345 10+1 December 4, 2012 30. Name and address of person Piyush Patel, cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring,MD 20910 MD 31. Date filed (Month, Day, Year)
DEC 05 2012

DHMH 17 Rev 06-2011

State Registrar

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42675 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **GEORGE** 2012 **EDWARD** JR. DEC. 8:28 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Hours · 1925 ocT. 20, BALTIMORE Director 214-20-0606 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No MARYLAND BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 216 MYSTIC WOOD ROAD 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Specify: WHITE Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 2 should be filed within 72 Ith and Mental Hygiene.
27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) CITY GOVERNMENT FIREFIGHTER 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 **EDWARD GEORGE** MARY V. POWELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is EDWARD L. GEORGE III/SON 216 MYSTIC WOOD ROAD, REISTERSTOWN, MD 21136 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 ื Cremation 3 🗆 Removal from State CREMATORY OF DELMARVA 12/12/12 4 Donation 5 Other (Specify) DELMAR, DELAWARE 21. Signature of Furjeral Service Licens 22. Name and Address of Facility Þ HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and I-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): use as the burialphysician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ō in the past 12 months? Month Year Pregnant at time of death 2 No Yes 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this certificate has been sinn Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be Division of Vital funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/2 No ဂ္ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending 1 Yes 2 No 2 Accident Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C1-0005489 12/10/12 DE 19969 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GALLAGHER 35141 ATLANTIC AUE MILLUILLE KIMBERLY Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12/07/2012 BETTY DAVIDSON HAYNES 1:18 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **EASTON** TALBOT DIXON HOUSE Social Security Number if Under 1 Year If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) LONG to BRANCH Days Hours Min. **Director** 228-20-9791 1 - M 2 X F 86 WASHINGTON 05/07/1926 28a-f shov "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director TALBOT **EASTON** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 N. HIGGINS ST. 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: WHITE 3 X Widowed 4 Divorced Specify Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ? should be filed within 72 h h and Mental Hygiene. ? Is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **BROKER** REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ LONA MCALLISTER ELMORE ELKINS DAVIDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Health item 27 i 29444 OAK RD. EASTON, MD 21601 JEFFERSON L. HAYNES/SON 20a. Method of Disposition CHESAPEAKE CREMATION Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/10/2012 STEVENSVILLE, MD CENTER 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 쿠드마아WSddrenelfenbein & Newnam Funeral Home, PA. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that coused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 2 🗆 No 1 Yes Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) ASST. LIVING 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 5 Pending 1 Natural injury work / 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00051132 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JORGE H. ABREGO, MD 598 CYNWOOD DRIVE, STE. 104, EASTON, MD 21601 31. Date filed (Mon Par Year) 2012 State Registrar

Baltimore, Maryland 21215-0036

Box 68760 P.O. Records, of Vital Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AC 12 2012 Medical 4b Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 6000 Douthen ARTIAND inton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplade Social Security Number State or Foreign **Funeral** 231-74-2544 Director 1 X M 2 - F -195 12 IniA Usual Residence of Deceden 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, <u>the Medical Examiner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10c. City, Town or Location 0d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Waldor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Temi 20601 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes. Give Black Completed 3 Widowed 4 Divorced 1973 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Office 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) Address (Street and Number or Rural Ro ite Number, City or Town, State, Zip Code) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location City or Town, State permit. Page 1 and Department of Pluportant: If its any injury or ot once. M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) MALLA 22 ehmon 21. Signature Juneral Service Licensce 20607 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ oronas disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 1 ☐ Yes 2 ₺ No After this certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 👿 No Certificate: To 1 Inpatient 2 NER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of cortifie 29d. Date signed (Month, Day, Year) 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	State of Marylan		artment of F		d Mental I		012	42678
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	inicate or	Dealli	2. Date of	Reg. No. Death	·	3. Time of Death
	Physicia		Toussaint Loverture	e James. Sr.				Decen	Day	7017	4:230
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of D			unty of Death	
1			Aurora Senior l	iving on M	anokin	Princ	ess f	thne	S	mer	set
	Funeral		5. Social Security Number 6. Sex	J. Age in yrs. M 2□ F 83	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Hrs. 8. Date of (Month)	Birth , Day, Year)	Col	pplace (State or Foreign untry)
	Director		218-24-5138 Usual Residence of Decedent	0.3	, 10.			05/13	/1929	Mai	yland
	yland how at		10a, State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	e Mar Ba-f s	Director	Maryland Wicomico	Sal	isbury						1 □ Yes 2Ñ No
	vith th	Dire	10e. Street and Number			10f. Zip Code				of What Cou	untry?
	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	Funeral	410 Hearne Lane	2. Was Decedent Ever in U.	6 12 1	21801 Vas Decedent of H	llepanie Origina	? (Specify Vos o	US	A Race - Amer	ican Indian
0	fter d r item niner	Fun	11. Marital Status 1 ☐ Never Married 2 ☑ Married	Armed Forces? 1y Tyes 2 □ No If Yes, Give	1	f Yes, specify Cuba	an, Mexican, Pu	uerto Rican, etc.		Black, White	
ž	ral", o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	∐Yes 2∛∭XNo	Specify:		Sp	ecify: Bla	ick
21215-0036	72 ho 'natur	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	(Give	lent's Usual Occup	during most of	working	16b. Kind o	of Business/I	ndustry
2	vithin ene. than '	ld m	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	,		Delma	arva Po	ower
0	filed y Hygid Sther ent, III		12 17. Father's Name (First, Middle, Last)		meter	reader/e		NEUT Name <i>(First, Mic</i>			
/land	ild be fental rked c	To Be	William Henry Jame	s. Sr.			Paulin	e		Ballar	ď
Mary	should and N		19a. Informant's Name/Relationship (Type		19b. Mailin	g Address (Street					
*, ∑	and 2 ealth m 27 i		Mildred D. James/spo			earne La	ne - Sa	lisbury,			
ore Ore	ges 1 It of H If iter or oth		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Re	-	Place of Disposemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Locati	ion - City or T	own, State
aitimor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Its Maries Examiner must be notified at once.		4 □ Domation 5 □ Other (Specify)		inghill	Mem. Gd	Ins 12/	15/2012	Hebro	on, Ma	ryland
0	permi Depa Impo any Ir		21 Signature of Funeral Service License	(hoo.		. Name and Addre				d – Sa	lisbury, MD 801
			23a. Part 1. Enter the disease, or complication	ations hat caused the leath			F-37-1-378			21	Approximate
- F	Physician		shock, or heart failure. List only one Immediate Cause (Final	causi on each live	4	71/8					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):	CVI					
Г	Examiner		Sequentially list conditions. b.								
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):						
_	execu n and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
,00	ficate be executed physician and s the burial-transit	dical	d.								
0	ng ph	Medi	IF FEMALE:								
2	eath certific attending p for use as f	lan/I	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregna 1 Live birth 2 Feta	Ideath 3	Ectopic pregnanc	у		23d	. Date of deli Month	very Day Year
5	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of d 9 ☐ Unknown	ieath 5□	Other (specify) _			-	WOITH	Day Year
Ľ	res that the de signed by the a be detached t		Part II. Other significant conditions conti	ributing to death but not resu	ulting in the ur	derlying cause giv	en in Part I.	23e. [id tobacco use	contribute to	the cause of death?
ords,	quires in sign	d by	Diahe	TIC Neur	0 7972	7		_ 1	□Yes 2□N	lo 3□ Pro	bably 4 Unknown
3	ne lav require has been sig ge 2 should b	Completed				/		24a. V	Vas an 2	4b. Were au	topsy findings available ompletion of cause of
֡֓֞֓֓֓֓֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	The late ha	L Com				·	.=	p	utopsy erformed? es 2 No	death?	ompletion of cause of 2 □No
9	clan: ertific sctor, l	Be C	25. Was case referred to medical examiner?				26. Place of I	Death (Check or			
5 8	ding Physician: The h. h. After this certificate h. funeral director, page	မ	1 ☐ Yes 2 ☐ Ño Ho	spital: 1 Inpatient 2			4 Nursin	ng Home 5 🗆 F			eify)
5	ding h. After funer	tion	27. Manper of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl	yat <br Yes 2 ⊟No	28d. Descr	be how injury or	ccurred	
2	Atten r deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre		163 2 110	28f. Location	n (Street and N	umber or Ru	ral Route Number,
5	s afte	Certification:	4 ☐ Homicide determined	building, etc. (Specify	<i>y)</i>			City or	Town, State)		
1	lowine Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has seen signed by the attending tompletely filled in by the funeral director, page 2 should be detached for use as		(Check only 2 Medical Examine	cian: To the best of my knoer: On the basis of examina	wledge, death	occurred at the ti	me, date and p	place, and due to	the cause(s) an	d manner as	stated. to the cause(s)
94	ithin 2 the l	Medical	one) 29b. Signature and title of certifier	and manner stated.		00.11					2 16 1
ŀ	2 3 4 8 2		Noth			774	2094		1	2/6/1)
1	ITC		30. Name and address of person who com	apleted cause of death (Item	n 23a) (Type, I	Print)	1- 11			[4 [7	
	IVA		Vel NATES	an 951	1 4 1	11 Heru	an R	and 5	TLIS GUN	4 M	5 21804
	Stat Registra		31. Date filed (Month, Day, Year) OEC 1 2 2012	ipleted cause of death (Item	b. So	skel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 12 0745 Donna Marie Jackson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SALISBUIL 1100 MICO PENINSULA REGIONAL Medical Centu 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 117-46-5832 Director 60 Yrs 1 M 2 K F June 23, 1952 New York Usual Residence of Deceden f Heatth and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Wicomico 1 X Yes 2 No Delmar 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10 East Pine Street 21875 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ģ 1 Never Married 2 Married X Yes 2 □ No 1970-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 1972 white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 food service worker school Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Alfred Campany Colleen Shirley Marlowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Della Jones (Executor) 36269 August Road Delmar, DE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any Injury or ot 12-14-2012 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gardens Hebron, Maryland 22. Name and Address of Facility Short Funeral Home 21. Signature of Funeral Service Licensee wil 13 East Grove Street Delmar, DE 19940 23a. Part . Enter the disease, or complicate shock or hear failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Causs (Final HP2NIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Exami attending physician and I for use as the burlal-transit death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate funeral director, pag 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: A completely filled in by the ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and tile of certific 29d. Date signed (Month, Day, Year)

State

Registrar
DHMH 17 Rev 06-2011

TERNISHORE DR, SALISBURY, MD

completed cause of death (Item 23a) (Type, Print)

3 2012

		For State Registrar		State of	i iviai yiai	Cer	tificat			ariu iv		Reg. No.	211	2	426	680
Physicia	n/	1. Decedent's Name DAVID WES		,							2. Date of De		2)	12	3. Time of	f Death 36P M
Medic Examin		4a. Facility Name (if			ber)		4b. City	Town, or	Location	of Death	DECEMBI		County of I		23.	JOF ™
•		WASHINGTO						KOMA					NTGOM	ERY		
Funeral Director		5. Social Security Nu 231-44-34 Usual Residence o	16 1	x X M 2 □ F	7. Age (In yrs. 74	last birthday) Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da JULY 2.	ay, Year)		Counti	ace (State o y) INIA	r Foreign
f shov	tor	10a. State	10b. County	•		ty, Town or Lo	cation						•	10	d. Inside Ci	-
or 28e	Dire	MARYLAND 10e. Street and Nurr	PRINCE O	EORGES	loxo	N HILL	10f. Zi	n Code				10- Cai	zen of Wha	1 Court	- 55	s 2 □ No
s 23e c	eral	5201 WHEE						745			1		ED ST			
permit. Page 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hyglene. Importent: If Item 27 is merked other then "neturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Evancinar must be notified at once.	d by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Deced Armed Ford 1 Yes If Yes, Give	2 No		Was Dece f Yes, spe I 🗀 Yes				ecify Yes or No- Rican, etc.)		14. Race - / Black, V Specify:	Vhite, e	tc.	
2 hours "netur	plete		15. Decedent's Ec		es.	16a. Deced	dent's Usu kind of wo	al Occupa	ition	t of worki	ina		nd of Busin			
vithin 7; plene. or then	Completed	12TH GRAD	ndary (0-12)	College (1-	4 or 5+)	life. Do	RATOI	e retired)	anng mos	. or work	''y	CHE	MICAI	. co	MPANY	
d be filed v fental Hyg rked othe tic event,	To Be	17. Father's Name (F									e (First, Middle,			JON	ES	
12 should alth end h 27 is me		19a. Informant's Na. PEGGY L.		•			-				N HILL.					
e 1 and t of Hea If Item or othe	. 15	20a. Method of Disp	<u> </u>			Place of Dispo cemetery, cren	sition (Na	ne of	Ť		Date		cation - Cit			
nit. Pag artment ortent: Injury o		4 Donation	5 Other (Specifi)	HER						18,201		DORF,	, MA	RYLAN	<u>D</u>
permi Deper Impor eny Ir		21. Signature of Fun	THORNTO	N JOHNS	SON MOC	583 3	HÖRN 439 I	ON F	UNER/ GSTO	YL HO V ROA	OME, P.A.	A. IAN H	EAD,	MAR	YLAND	2064
		23a. Part 1. Enter the shock, or hear Immediate Cause (F	t failure. List only or	lications that can be cause on each	aused the dea th line.	th. Do not ente	er the mod	le of dying	, such as	cardiac o	or respiratory ar	rest,			Approximat Interval Bet Onset and I	ween
Physician/ Medical		disease or condition resulting in death)		a. Due to (c	or as a conseq	uence of):	+							+	Onset and t	Jean
Examiner	<u>.</u>	Sequentially list cor	nditions,	EN	TERD	LIAS	EDU	SF	STU	LA						
ted I Insit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	lying njury	Dietolo	ras a curiseq RCTC		LLIT	US						1		
icete be executed i physicien and is the burlei-transit		that initiated events resulting in death) L		Due to (c	r as a conseq		0011				-					
cete be physic s the b	de dical			d										\pm		
th certif ttending or use e	I€ I	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		Birth 2 🗍 Fet ant at time of	al death 3	Ectopic Other (s		/			2	23d. Date o Month		•	Year
uires thet the dee n signed by the e lid be detached f		Part II. Other signifi	icant conditions	ntributing to de	ath but not re	sulting in the u	nderlying	cause give	en in Part	I.	23e. Did t	obacco us	se contribu	te to the	cause of d	leath?
requires been sign should be	Completed by										10	Yes 2	⊠No 3ĺ	Prob	ably 4 🗌	Unknown
The lew re ete has be page 2 sh	mple										24a. Was auto			r to com	sy findings a pletion of c	
siclen: The certificete irector, pag	0	25. Was case referre	ed to medical					26 Pla	ce of Dea	th (Check		2 🗵 No		Yes 2	No No	
nysiclen: nis certific I director,	70 B	examiner?	I No	Hospital:	npatient 2	ER/Outpatien	nt 3 🗆 D	Otho	r _		me 5 🗆 Resi	dence 6	Other (S	Specify)		
ding Pl h. After th funera		27. Manner of Death 1 🔼 Natural	5 Pending		f injury n, Day, Year)	28b. Time of injury	- 1	28c. Injury work?	?	. 1	28d. Describe I	how injury	occurred			
l or Attener after deat Director: d in by the	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place o	of Injury - At h g, etc. (Specif	ome, farm, stre	M eet, factor		Yes 2	_	28f. Location (City or Tov		Number o	r Rural F	Route Numb	per,
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check 2	Certifying Phys Medical Examin Certifying Nurs	ner: On the basis	s of examination	on and/or invest	tigation, in	my opinior	n, death oc	ccurred at	the time, date a	and place.	and due to	the caus	e(s) and ma	inner stated.
Vithi To th		29b. Signature and t		^		5.7		. License		2		29d. Date	e signed (M	onth, D	ay, Year)	2
25		30. Name and addre	es of porson title	ompleted same	of death //+	n 22a\ /ī	hint\	U4t	74	1		DEC	EMBE	RIC),201	7
Dr.		VI COR	ONYGIA	KA 73.	25AH	Artoves	R-PAK	KWA	Y GA	REEN	BELT N	ARYL	AMO	20	770	
Stat	е	31. Date filed (Month	n, Day, Year)	32. PE	gistrar's Signa	ature		,								

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Physician Medica Examine Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit Division of Vital Records, P.O. Box 68760

	Please Type or Print				_	•
	for State of Mary State of Mary Registrar		nt of Health and N te of Death	nental Hygier Reg.	_	42681
/	1. Decedent's Name (First, Middle, Last) By House Nicole Je	ffers		2. Date of Death Month December	Day 5 Year 201	3. Time of Death 2 (27):25 A M
r	4a. Facility Name (if not institution, give street and number)	4b. Cit	y, Town, or Location of Death		4c. County of Dea	th
		, ro. race 2	er 1 Year If Under 24 Hrs.	8. Date of Birth	1	thplace (State or Foreign
	154-88-9071	Yrs. Month	B Days Hours Min.	March 18	8, 1990 ^{co}	NJ
ector	10a. State 10b. County 10	c. City, Town or Location				10d. Inside City Limits
runeral Directo	10e. Street and Number 1212 THORNTON AVE		ip Code	10g. US	Citizen of What Co	ountry?
Lane	11 Marital Status 12. Was Decedent Ever	in U.S. 13. Was Dec	060 edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
ted by	1 Never Married 2 Married Armed Forces2 1 Yes 2 No 15 Yes 2 No 15 Yes 2 No 15 Yes Give Year or Dates.		2 🕅 No Specify:	nicali, etc.,	Specify: BL	e, etc. ACK
Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 TH	16a. Decedent's Us (Give kind of w life. DO NOT u	ork done during most of work se retired)	ing	. Kind of Business	Industry
D D	17. Father's Name (First, Middle, Last)	SALES AS		e (First, Middle, Maid	RIVATE en Surname)	
2	KEVIN L. JEFFERS		CARLETTA	A D. PHI	LLIPS	
	19a. Informant's Name/Relationship (Type, Print) CARLETTA JEFFERS MOTHER KEVIN JEFFERS/FATHER	1212 THO	ss (Street and Number or Rura RNTON AVE. PLA	INFIELD.	NJ 07060	
	1 Rurial 2 Cremation 3 Removal from State	Ob. Place of Disposition (Note that the completery, crematory or CEM)	ether place) ETERY 12-12	2-12 P	. Location - City or LAINFIEL:	D, NJ
	21. Signature of Funeral Service Licensee	5538 1	and Address of Facility PC MARLBORO PIKE	PE FUNERA FORESTVI	_	
	23a. P 1 1. Enter the discase, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
		Myelo munucy nsequence of):	hic Leukemia			5 months
<u>.</u>	Sequentially flet conditions, if any, leading to immediate Due to (or as a co	splant S	yndrome			15 months
100	cause. Enter Underlying Cause (Disease or iinjury that initiated events	iutation with	Acute Myel	igenous L	cuhemia	15 years
loa L	resulting in death) Last Due to (or as a co	nsequence oi):		<i>V</i>		
	IF FEMALE:				21/202	
y sicial!	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at tim 9 Unknown	Fetal death 3 🔲 Ectopi			23d. Date of de Month	livery Day Year
ou my ri	Part II. Other significant conditions contributing to death but n	ot resulting in the underlying	g cause given in Part I.	23e. Did tobacc	VI _	o the cause of death?
nalaldillo				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical examiner?		26. Place of Death (Check	1 ∐ Yes 2 X k o <i>nly</i> o <i>n</i> e)	No I te	s 2 No
2	Hospital:	2 ER/Outpatient 3 28b. Time of		ome 5 🗆 Residence		cify)
במוני	1 X Natural 5 ☐ Pending (Month, Day, Ye 2 ☐ Accident Investigation		28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury-building, etc. (S)	At home, farm, street, factoriecify)	ry, office	28f. Location (Street City or Town, Sta		ral Route Number,
Medica	29a. Certifier (Check only one) Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam only one) 3 Certifying Nurse Practioner: To the best	nation and/or investigation, i	n my opinion, death occurred a	t the time, date and pla	ace, and due to the	cause(s) and manner stated.
-	29b. Signature and title of certifier Andrew Miller M.	29	D74151	29d.	Date signed (Mont	p, Day, Year) 2012
	30. Name and address of person who completed cause of death Andrew C Miller	(Item 23a) (Type, Print)	- Drive Be	thesda	MD:	20892
	31. Date filed (Month, Day, Year) DEC 1 4 2012 2. Registrar's S					
	Maria A Wanta					

DHMH 17 Rev 7/2009

350

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roberta King Lee 403 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Meritus Medical Center Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, Year) 215-34-0321 75 Director 1 □ M 2 🗓 F Aug. 16, 1937 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director Washington Williamsport MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 154 Artizan Street 21795 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 ☐ Divorced Specify: Caucasian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) US Air Force Secretary Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Duckett Virginia Hammett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward King/Son 32127 6112 Palmas Dr.,Port Orange,FL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Fairfax Memorial Dec 2012 1 Durial 2 Cremation 3 Removal from State Fairfax, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Andrew K. Cofiman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, CC 0423 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of: attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown has teen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 ☐ Yes 2 ☐ No Yes director, e B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After t Certificate: 28d. Describe how injury occurred 1 Natural 5 Dending work? death. I Director: Af 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 24 hours after e City or Town. State) Medical 1 X rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 20 20063733 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Northern Ane Hacerston

Mahmoso

3. Registrar's Signa

filed (Month, Day, Year)

OEC 12 2012

	1	For State Registrar	State of Maryla		irtment of F tificate of L			giene Reg. No. 201	2 42683
Physician	/	1. Decedent's Name (First, Middle, Last) Konica K. Ki	ngwood				2. Date of De Month Decembe	Day Yea	3. Time of Death 0946 A M
Medica Examine		4a. Facility Name (if not institution, give str Suburban Hospita	eet and number)		4b. City, Town, or Bet	Location of C	"	4c. County of De	
Funeral Director		5. Social Security Number 6. Sex		s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Da	y, Year) (Birthplace (State or Foreign Country) DC
Maryland 8a-f show tiffied at	Director	10a. State 10b. County DC	10c.	City, Town or Loc		shingto		, 1501	10d. Inside City Limits 1 🙀 Yes 2 🗀 No
h with the I ns 23a or 2 must be no	Funeral Di	10e. Street and Number 2661 Staton Road S				0020		10g. Citizen of What United	1
U L.⊞ I	2	11. Marital Status 1 ☐ Never Married 2 🍱 Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	lf	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🗷 No	n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, Wi Specify:	nerican Indian, nite, etc. Black
21215-0036 within 72 hours after giene. "natural", o, the Medical Exami, the Medical Exami	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give k	ent's Usual Occup ind of work done of NOT use retired)		working	16b. Kind of Busines	
Maryland 2 2 should be filed w Ith and Mental Hygi 27 is marked other traumatic event, if	ωŀ	7. Father's Name (First, Middle, Last)	Hollins Sr.		unemp		Name (First, Middle,		iie
Mary nd 2 shoul ealth and N m 27 is m ner traums		19a. Informant's Name/Relationship (Type Vanessa Hollins –	Mother	2661	Staton Ro		r Rural Route Numbe	er, City or Town, State, Washingto	Zip Code) on, DC 20020
tant jury		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)			atory or other plac unk		Date unk.	20c. Location - City	unk.
Ball permit Depart Impor any in		21. Signature of Funeral Service Licensee John F. Stewar 23a. Part 1. Enter the disease, or complice	1100.	560 4		ing Ro	ad NE Was	Funeral Homshington, I	
Division of Vital Records, P.O. Box 68760 the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit property of the funeral director. To Re Completed by Division Medical Examiner	dical	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a cons	equence of):	LONIA				Interval Between Onset and Death
Records, P.O. Box 687 The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	nysician/m	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of prec 1	etal death 3	Ectopic pregnance Other (specify)	У		23d. Date of o Month	delivery Day Year
ecords, P.O e law requires that t s has been signed b ige 2 should be dete	eted by P	Part II. Other significant conditions control	ributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.	1 🗆	Yes 2 ØPNo 3 □	to the cause of death? Probably 4 Unknown
of Vital Records, of Physician: The law requires ter this certificate has been signeral director, page 2 should		25. Was case referred to medical			26. Pla	ace of Death (24a. Was autor performance 1 Yes	prior to pri	o completion of cause of
ivision of Vital or Attending Physician after death. Director: After this certif in by the funeral directo	2	examiner? 1 Yes 2 No Ho: 7. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	spital: 1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆	4 ∐ Nursi: rat	28d. Describe h	dence 6 Other (Sp	
Division of To the Hospital or Attending Rwithin 24 hours after death. To the Funeral Director: After completely filled in by the funeral Madiral Cartificates		4 Homicide determined 29a. Certifier 1 Certifying Physici	28e. Place of Injury - At building, etc. (Spen an: To the best of my kn	cify) owledge, death o	ccurred at the time	, date and pla	City or Tow	ause(s) and manner as	stated.
To the Ho within 24 To the Fu completely	Medical	(Check 2 Medical Examiner only one) 3 Certifying Nurse F	: On the basis of examina	ation and/or investi of my knowledge,	gation, in my opinio death occurred at the 29c. License	n, death occur ne time, date a	rred at the time, date a and place, and due to t	and place, and due to th	e cause(s) and manner state r as stated. onth, Day, Year)
		30. Name and address of person who com Truong Bao, MD 1	opleted cause of death (It	tem 23a) (Type, Pi	rint) 7e Rockvi			/ ((()	L
State Registrar	3	1. Date file DEC 1 Pay 4 2012	32. Registrar's S	nature and	1				

	1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 42684												
			Registrar 1. Decedent's Name (First, Middle, Last)	unicate of Death	Reg. I		e of Death						
	Physicia		Helen Violet Lentner		December	9, 2012 11:	25 am						
Anna	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	1c. County of Death							
			Holy Cross Hospital	Silver Spring	1	Montgomery							
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthplace (Sta Country)	te or Foreign						
	Director		386-32-1031 1 □ M 2 🛂 F 80 Yrs.		Feb. 25,	1932 Michigan							
	and show	ō	10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside	e City Limits						
	Maryl 28a-f otifiec	rect	MD Montgomery Sil	ver Spring		1 🗆	Yes 2 X No						
	h the	alD	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?							
	th wit ms 23 must	Funeral Director	1615 Sherwood Road	20902		USA							
"	or ite	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	14. Race - American Indian Black, White, etc.	,						
03(iral", Exar	ed b		1 ☐ Yes 2 🖾 No Specify:		Specify: White							
5-0	2 hou "natu	plet		dent's Usual Occupation kind of work done during most of work	king 16b.	Kind of Business/Industry							
121	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	O NOT use retired) **Se	м	edical							
d 2	led wi Hygid other ent, t	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nan	ne (First, Middle, Maide	n S <i>ur</i> na <i>me</i>)							
ılan	d be filed Aental Hyg irked oth	오	Ira Cranstin Westphal	Helen	Helen Violet Foster								
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once.			ng Address (Street and Number or Rui									
e, N	and 2 Health em 27 ther t		Lori Lentner Schwartz/Daughter 1050	3 Cascade Place,									
nor	age 1 and of the triffit		1 Burial 2 Cremation 3 Removal from State cemetery, cre-	matory or other place)	c. 14.	Location - City or Town, State	3						
Ħ	nit. Pa artme ortan injury			Memorial Park		ckville, MD							
B	Dep Imp any onc		L	00 University Blv			20901						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,	Approxi Interval	mate Between						
æ I	Phi/succion/		Immediate Cause (Final disease or condition Pneumonia			Onset a	nd Death						
7	Medical Examiner		resulting in death) Due to (or as a consequence of):	D.1									
		Jer	Sequentially list conditions, if any, leading to immediate Bestrictive Lung Due to (or as a consequence of):	Disease									
	Ausit que	Examine	Cause, E. iter Underlying Cause (Disease or injury that initiated events C.										
	ate be executed hysician and the burial transit	at Ex	resulting in death) Last Due to (or as a consequence of):										
9	ate be ohysic the bu	dical	d										
687	ertifica ding pl	ŽΜ	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery							
Вох	death certifica ne attending pl ed for use as t	Physician/Me	in the past 12 months? 1 Live Birth 2 Fetal death 3 in the past 12 months? 4 Pregnant at time of death 5 in the past 12 months?	Ectopic pregnancy Other (specify)		Month Day	Year						
-	the d by the tached	hys	g ☐ Unknown										
	requires that the death certifica been signed by the attending p should be detached for use as	þ	Part II. Other significant conditions contributing to death but not resulting in the			o use contribute to the cause	_						
rds	equire een si nould	eted	Parkinson's Disease, Hypertension, A	nemia,		21 No 3 Probably 4							
of Vital Records,	Physician: The law requires rthis certificate has been sig aral director, page 2 should b	Completed	Aortic Stenosis		24a. Was an autopsy performed	24b. Were autopsy findin prior to completion death?							
Ä	ysician: The law is certificate has director, page 2		25. Was case referred to medical	26. Place of Death (Chec	1 🗌 Yes 2 😾								
Vita	/sicia s cert	To Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatie	_ Other:	lome 5 Residence	6 ☐ Other (Specify)							
0	ng Phys ter this ineral di		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury		28d. Describe how in								
ion	Attending or death. sctor; After by the fune	ifica	2 Accident Investigation	M 1 Yes 2 No									
-	or Att after d Direct I in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route N te)	umber,						
Q	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director, After thi completely filled in by the funeral I.		29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place,	and due to the cause(s) and manner as stated.							
	he Ho in 24 h he Fui pletel	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation on the basis of examination and/or investigation on the basis of examination and/or investigation of the basis of examination and or investigation of the basis of examination and or investigation of the basis of examination of the basis of the basis of examination of exa				I manner stated.						
_	To the Hospital o within 24 hours aft Completely filled in		29b. Signature and title of certifier	29c. License number D34472		Date signed (Month, Day, Year, ecember 9, 201							
	6						-						
			30. Name and address of person who completed cause of death (Item 3a) (Type, Lynne Diggs, MD 10400 Connecticut	Ave., #206, Kens	ington, MD	20895							
	Stat Registra	te ar	31. Date filed (Month, Day, Year) UEC 1 2 2012 Registrar's Signature	Kind.									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $\frac{\text{Month}}{12}/02/\frac{\text{Day}}{2012}$ **Physician** 1:25am^M Aneykutty Mathew /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 03/05/52 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 □ M 2 K F 60 India Director 213-49-9298 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at once. 1 XYes 2 ☐ No Silver Spring Director Md Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 12069 Crimson Lane 20904 India Funeral Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thankamma George Commen George ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12069 Crimson Ln Silver Spring, Md 20904 Daughter Juby Mathew 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 12/08/12 Silver Spring, Md Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) Shead Funerally Home and Cremation 21. Signature of Funeral Service License Row 5732 Georgia Ave NW Washington, DC 20010 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Arrhythmia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Renal Failure Be Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellites 24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation thin 24 hours after death.

the Funeral Director: After the function by the function of the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 12/04/2012 D-20062 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8201 16th St. Silver Spring, Md Kannarkay, M.D. Tony 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 05 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Marzouka 065 SM Homantine 2013 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9 10605 -ava ver Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min (Month, Day, Year) Hours Director 1 □ M 2 🗚 None 79 05/16/1933 Haiti permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location Completed by Funeral Director 1 X Yes 2 ☐ No Florida Dade Miami 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Haiti 11960 SW 99th Street 33186 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Błack, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛂 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify If Yes, Give Specify: White 3 ₺ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wadia Bitka Bicharra Jiha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Al Rayes / Daughter 12002 SW 102 St. Miami, Florida 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/06/2012 Haiti Du Souvenir Signature of Fundral Service Ligensee 22. Name and Address of Facility Joseph Gaawler's Sons LLC. DC 20016 CC00379 <u>5130 Wisconsin Avenue NW Washington,</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Onset and Deatl -Physician/ disease or condition resulting in death) Medical Due to (a) as a consequence of) Examiner Sequentially list conditions, dray, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ate has been signed by the a page 2 should be detached a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has 1 Yes 2 No Yes after death.

Director: After this certific:
d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No 잍 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending 2 ☐ Accider 3 ☐ Suicide Accident Investigation 6 Could not be within 24 hours after de
To the Funeral Directo
completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, geatin occurred at the time, date and place, and que to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Young) 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ature and title of certifie MO OME CGGUTY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Ma	aryland		irtment of F tificate of L		and M		giene Reg. No.	2012	42687
	Physicia		Decedent's Name (First, Middle, Last DAISY KATHLEEN		ELD					2. Date of Dea Month December		2012	3. Time of Death 4:20 PM
	Medic Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or		of Death	Decemb	4c. C	ounty of Dea	th
	Euneval		Casey House-Mong 5. Social Security Number 6. Security Number 6. Security Number 16.		olce e (In yrs. las	st birthdav)	Rockvil	Le If Unde	24 Hrs.	8. Date of Birth		ont gon	thplace (State or Foreign
Į	Funeral Director			□м₂∏т	88	Yrs.	Months Days	Hours	Min.	(Month, Day June 1	(Year)	Co	England
	/land f show ed at	tor	10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
	r 28a- notifie	Direc	Maryland Montgome	ery	Pot	omac	10f. Zip Code				10a Chia	en of What Co	1 ☐ Yes 2 🌠 No
	s 23a o	Funeral Director	9505 Reach Road				208	54			Eng1		odinity :
036	e filed within 72 hours after death with the Maryland Hyglene. Hyglene et of the Han "natural", or items 23a or 28a-f show et ofter than "natural", or items 25a or 28a-f show event, the Medical Examiner must be notified at.	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 No										erican Indian, te, etc. hite
ر ک	2 hour "natu edical	3 Midowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Specify Specify Specify 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Administrator Priv										d of Business	/industry
212	within 7 glene. er than the Ma		Elementary/Secondary (0-12)	College (1-4 or 5	+)		NOT use retired) .nistrato	r			Priv	ate Li	Lterary
and	ould be filed with nd Mental Hygler i marked other t imatic event, th	To Be	17. Father's Name (First, Middle, Last) Unknown Redfo	rd	•					(First, Middle, in Wheat			
Ĕ	上 来 9 2	19a. Informant's Name/Relationship (Type, Print) Angela M. Anixt (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 9505 Reach Road, Potomac, MD 20854											ip Code)
Baltimore,	Page 1 and 2 s nent of Health a ant: If item 27 i ury or other tra		20a. Method of Disposition 1 ☐ Burial 2 汉 Cremation 3 汉	Removal from State	ce	metery, crem	sition (Name of natory or other place	ce)	Dec 20	ate		•	r Town, State
altı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Ho												
1	20729		23a. Part 1. Enter the disease, or com	<u> </u>	01116							burg,	
~ F	hysician/		shock, or heart failure. List only o Immediate Cause (Final disease or condition		Approximate Interval Between Onset and Death								
	Medical Examiner		resulting in death)	Due to (or as a	a conseque	ence of):							
	Feit and	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):							
9	icate be executed in the purishment is the burishment	edical Examiner	that initiated events resulting in death) Last	Due to (or as a	a conseque	ence of):							
9/8	tificate ng phy e as th		IF FEMALE:										
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The lew requires that the death certificate be executed within L4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buring completely filled in by the funeral director, page 2 should be detached for use as the buring the page 2 should be detached for use as the buring the page 2 should be detached for use as the buring the page 2 should be detached for use as the buring the page 2 should be detached for use as the buring the page 3.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	у			23	3d. Date of de Month	elivery Day Year
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<u>a</u>	ician: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Oth	or.	ath (Check				
<u>o</u>	g Phys er this neral di	te: To	27. Manner of Death	1 ∐ Inpation 28a. Date of inju (Month, Day	ry 2	R/Outpatier 28b. Time of injury	at 3 □ DOA 28c. Injur	4 U I		me 5 Resid			cify) Hospice
noi	ttendin death. :tor: Aft / the fu	Certificate;	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	1			M 1 🗆	Yes 2	_	201	4 4- 1		1 Po 1 A 1 1
DIVI	tal or A rs after al Direct led in by												urai Houte Number,
	the Hospi nin 24 hou the Funer npletely fil	Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of iner: On the basis of e se Practitioner: To the	xamination	and/or invest	igation, in my opinio death occurred at	on, death o	occurred at	the time, date a	nd place, a	ind due to the	cause(s) and manner stated.
	4 So of Will		29b. Signature and title of certifier	Enlean			29c. Licens		237	. 1		signed (Moni	
			30. Name and address of person who a Dr.Jay L. Patank	ar M.D. 60	eath (Item 2	23a) (Type, F incast	rint) er Mill]	Road,	Derv	vood, M			
	Sta Registra		31. Date filed (Month, Day, Year) UEC 05 20	12 32 Registra	ar's Signatu	. pa	whole.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42688 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Malcom Susan Irene 2012 Medical December 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbury Wicomico <u>Wicomico Nursing Home</u> **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Months Hours (Month, Day, Year) Director 220-01-3850 1 M 2 TF Yrs 90 01/23/1922 North Carolina Usual Residence of Decedent er then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 . No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 707 Schumaker Lane USA 11. Marital Status 12 Was Decedent Ever in LLS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, É 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clothing Manufacturer Bookkeeper I Hygier Be intury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file and Mental H is marked o ဥ James Albert McKelvey Martha Hunter 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any infury or other traum once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5251 Green Hill Circle, Quantico, MD 21856 Wanda C. Surricchio/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Springhill Memory Gardens 12/15/2012 Hebron, MD LEureryl Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregpant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month 1 Yes 2 No 9 Unknown Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? 1 Yes 2 No Be 25. Was case referred to edical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗌 No Watural 5 Pending neral Director: A after death ☐ Accident ☐ Suicide м Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

syspin Malcom

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42689 state amended item #26-te-wchd-12/1**Gertific**ate of Death 2. Date of Death 3. Time of Death Month Physician/ 07:45 Jean Florence Mover 2012 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Pittsville 35328 Laws Road 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours Director 1 🗆 M 2 🛣 F 171-22-2587 Yrs 85 Pennsylvania 09/22/1927 Usual Residence of Deced 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State Director 1 X Yes 2 No Worcester Twp.- Lansdale Pennsylvania Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 19446 Meadowood at Worcester, 152 Azalea House 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental F Page 1 and 2 should be fill ment of Health and Mental ant: If item 27 is marked Alverta Kleintop Christian Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2770 Lantern Lane, Audubon, PA 19403 Gary S. Moyer/Son 20a, Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 🗓 Removal from State R cemetering crametors or other place) 12/10/2012 Funeral Home Skippack, PA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP Wampan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arkinson's disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and defached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24 hours after death. Funeral Director: After this certificate has been signerely filled in by the funeral director, page 2 should betely filled in by the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 7 No 1 🗌 Yes 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 The sidence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending injury work? 2 🗆 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 ho To the Fune completely f (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signat 510 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO BX1733

State Registrar

			For State of Maryland / [Depa	rtment of h	lealth and	d Mental Hy	giene	ogibioi			
_			1 - State Registrar	Cert	ificate of L	Death		Reg. No.	2012	42690		
	Physicia		1. Decedent's Name (First, Middle, Last) Gladys Yarborough Moore				2. Date of De Month DeC •	ath Day 7	20 ^{Year}	3. Time of Death 4:55 P M		
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	r Location of De		- ' -	ounty of Death	14.55 1		
لمحر			5420 Danby Ave.		Oxon				ince G	eorge's		
Ā	Funeral Director		5. Social Security Number 243 64 2198 1 \(\text{ \ Age} \) 1 \(\text{ \ Age} \) 3 1 \(\text{ \ Age} \) 1 \(\text	hday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		v. Year)	Coun	place (State or Foreign try) NC		
	land show	tor	10a. State 10b. County 10c. City, Town	n or Loca	ation				1	10d. Inside City Limits		
	Mary 28a-i	Director		on I	Hill					1x Yes 2 ☐ No		
	vith th	ral	10e. Street and Number 5420 Danby Ave.		10f. Zip Code 207	45		10g. Citize	n of What Cour	itry?		
	leath v items er mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W			(Specify Yes or No- erto Rican, etc.)		. Race - Americ			
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	(Give ki	ent's Usual Occup ind of work done of NOT use retired)		vorking	16b. Kind	of Business/Inc	dustry		
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Maryland	be file antal H ked of c ever	To B	17. Father's Name (First, Middle, Last) James Yarborough				Name (First, Middle, Allen	Maiden Sui	name)			
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Baltimore,	ge 1 an nt of H if item or oth		1X Burial 2 Cremation 3 Removal from State cemeter	ry, crema	ition (Name of atory or other plac		Date		tion - City or To			
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Division of Vital Records,	aw require as been si 2 should I	Completed					24a. Was auto			osy findings available mpletion of cause of		
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ita	sician certifi irector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou		Oth	ace of Death (C						
of V	g Physer this seral d	e: To	27. Manner of Death 28a. Date of injury 28b. T	Time of	3 L DOA 28c, Injun	4 ∐ Nursing y at	g Home 5 Residence 1 28d. Describe I)		
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N N	of or Attendi after death. Director: A d in by the f	Certificate:	4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, stree	et, factory, office		28f. Location (S City or Tox		umber or Rural	Route Number,		
Ω	spital	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death oc	curred at the time	e, date and place	e, and due to the ca	ause(s) and	manner as state	ed.		
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	2,5		20. Name and address of person who completed cause of death (Item 22a) (Type Pri	int)	7707		16	10-6			
	on		MicHAEL SidaRons, M.D. 1170	111	vingsta	- N) H	10) 4	spshi	:- jtan	Mp 20749		
	Stat Registra	e	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (MicHAEL SidARows, M.2.1170 31. Date filed (Month CEC at 22012 32. Fegistrar's Signature)	p	ares				0			
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lawrence C. Manning Dec. 10 2:32A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7709 Seans Terrace Prince George's Lanham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year) Director 230 30 3697 1**XX** M 2 □ F 83 April 5, 1929 Virginia "neturel", or items 23e or 28a-f show idical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Lanham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7709 Seans Terrace 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1XX Yes 2 No If Yes, Give Year or Dates Korean 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3XXWidowed 4 ☐ Divorced Completed **Black** 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tai Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Principal Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health end Mental H of Health end Mental H If item 27 Is marked of r other treumetic ever 2 John Manning Mary Bonner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Manning (Son) 7709 Seans Terrace, Lanham, MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Depertment of I
Important: If its
eny Injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cometery 12/19/2012 Cheltenham, MD 21. Signature of Funeral Gention Liverse 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 20015 Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Lymphoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): inding physicien end use as the burlai-trensit or Attending Physician: The lew requires that the deeth certificate be executed Due to (or as a consequence of): resulting in death) Last ed by the attending physicien detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by After this certificete hes been signe funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Tunknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Y B 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5XX Residence 6 Other (Specify) မြ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XXNatural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident Investigation 6 ☐ Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouatcheu, mo Joceline D6 3748

DOXXI

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month

Jocelyne Kouatchou, M.D. 201 East University Parkway, Baltimore, MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink Trasure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DEC. 2012 MUSCHETTE 0730 WILLIAM R. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Funeral Days Hours (Month, Day, Year) **Director** 579-54-3726 Usual Residence of Dece 1 ☑ M 2 □ F 71 Yrs. Aug. 15, 1941 MD 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20017 USA 906 Jackson St. NE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give à 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hampshire Towers 9th Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Frederic ၉ James Muschette ,Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Jackson St. NE Washington, DC 20017 Nancy Muschette - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12-2Pate2012 Page 1 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD Fort Lincoln Cemetery: 12-20-2012 21. Signature of Eugeral Service Licensee 22 Name and Address of Facility Marshall—March Funeral Home of Maryland clas 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exam the Hospital or Attending Physician: The law requires that the death certificate be executed Change of Mental Status that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Stroke Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 1 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖸 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manual of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Name and address of persop who completed cause of death (Item 23a) (Type, Print) 1500 FOREST GlENRY SILVER Spring MD MZF State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1558 Shirley Ann Nichols Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** HICOMICO SOLISBUR antu TENINS41A REGIONAL MEDICAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth Funeral Days Hours Min. (Month, Day, Year) Director 214-34-5988 1 🗆 M 2 💢 F 2-1-1936 76 MD or then "natural", or items 23e or 28e-f show the Medical Exprimer must be notified at 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 403 Maryland Avenue <u> 21875</u> Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married \$ 1 ☐ Yes 2X No "natural", or Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give spæbleack 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Farming Laborer e 1 end 2 should be filed wir of Health end Mental Hygie If item 27 Is marked other or other treumatic event, II Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ <u>George Wallace</u> Geraldine Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 end 2 sh it of Health en If item 27 Is <u>Retty West/Sister</u> 20a. Method of Disposition Hearne Lane, Salisbury, 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 e
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State 1 Burial 2 Department of Depar Direct Cremation, 12/17/2012 Dover, DE 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisbu 21. Signature of Funeral Service Licenses Isabella St. Russell Fooks per DVR Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASCVD disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin ettending physician and I for use as the burlal-transit ause (Disease or injury lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year ed by the el 9 Unknown 9 Unknown P.O. ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death-but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: autonsy or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 N 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending death. 2 Accident М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be within 24 hours after de To the Funeral Direct completely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 10 085 npleted cause of death (Item 23a) (Type, Print) 3 Perinsula MO regional State Registrar

		_	For State State Registrar	ate of Ma	ryland / De	partme ertifica	ent of F te of E	Health a Death	and Me	ntal Hy	giene,		42694
	Physicia	n/	1. Decedent's Name (First, Middle, Last)							Date of De	ath	, 20 ^{¥2} 2	3. Time of Death
	Medic Examin	al	Gordon Densmore Nortl 4a. Facility Name (If not institution, give street a			4b. Cit	v. Town, or	Location c		Jecemi		County of Death	2:00 PM
	LAGITATI		Suburban Hospital				thes	da				lontgome	ry
	Funeral Director		5. Social Security Number 6. Sex 1 M n 2	_	(In yrs. last birthda	Month	er 1 Year Days	If Under Hours	Min.	Date of Bir (Month, Da	ıy, Year)	Cour	
49	- 2		Usual Residence of Decedent		81 Yrs				(Oct. 1	1, 1	931 New	
	arylanc a-f sho fied at	ector	10a. State 10b. County Maryland Montgomery		10c. City, Town or Rockvil								10d. Inside City Limits 1 🏿 Yes 2 □ No
	the Man or 28	i Dir	10e. Street and Number			10f. Z	Zip Code	1			-	zen of What Cou	
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9	ter dea , or ite miner	by Fu	1 Never Married 2 Married 1	ped Forces? ☐ Yes 2 ☐ N	ver in U.S.				gin? (Specify n, Puerto Ric	an, etc.)		14. Race - Americ Black, White,	etc.
003	ours af ntural", sal Exa	Completed by	3 ☐ Widowed 4 ☒ Divorced Ye 15. Decedent's Education	al Ol Dates.	Korea			Specify:				Specify: Wh:	
215	n 72 hi e. ian "na Medic	Jdw	(Specify only highest grade con		-) (G	. DO NOT u	ork done o se retired)	during most	t of working		U.S	nd of Business/In Depar	tment
121	d withi tygiene ther th nt, the	o h	17. Father's Name (First, Middle, Last)	4	Ele	ctron	ic En					the Ar	ny
<u>lanc</u>	be file lental H rked of	ToB	William Richard Nort	n, Jr.					er's Name (F			,	
Maryland 21215-0036	should and N is ma		19a. Informant's Name/Relationship (Type, Prin Gary William North	(Son)		0	,					Town, State, Zip	
e, Z	and 2 Health tem 27		20a. Method of Disposition	(5011)	221 20b. Place of Di			w Tra	pate			llands,	VA 22148
in oil	Page 1 nent of ant; If i		1 Burial 2 Cremation 3 X Remove 4 Donation 5 Other (Specify)	al from State	cemetery.	opoli mator	tan plac	ce)	Decem 11, 2			,	Virginia
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Livensee	MOO	1689	22. Name	and Addres	ss of Facilit	y DeVo	1 Fun		Home,	MD 20877
			23a. Part Dater the disease, or complication	s that caused								SDUIG,	Approximate
2pm	Physician/			Pneumor	nia								Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a	consequence of):								
2012	=	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):								
<u>800</u>	executed an and ria transi	ical Examiner	Cause (Disease or injury that initiated events	Due to (or as a	consequence of):								
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Re	: The la icate har r, page	Con								perfo	ormed?	death?	2 🗆 No
(C) /ital	rsician s certifi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospita	l: X Inpatie	nt 2 🗆 ER/Outpa	tient 3 🗆		or	th (Check or	,	dence 6	Other (Specif	w)
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Sign	Attendi death. ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	. Place of Injur	y - At home, farm	M street, facto		Yes 2 🗆	-	f. Location (Street and	d Number or Rura	l Route Number,
D. Wil	tal or / rs after al Dire led in b		4 Homicide determined	building, etc.	(Specify)					City or To			
Vortherision of Vital Records	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit	Medical	29a. Certifier (Check 2 Medical Examiner: On Survey 3 Certifying Nurse Frag	the basis of ex-	amination and/or in	vestigation,	n my opinio	on, death o	ccurred at the	e time, date	and place,	and due to the ca	suse(s) and manner stated.
Z	To the I within 2 To the I comple		29b. Signature and title of certifier				9c. License	e number			29d. Dat	e signed (Month,	Day, Year)
	16+1		30. Name and address of person who complet			e. Print\	. 7ע	1517			De	Cemper C	, 2012
724		-	Natalia Maria Vasque	z Marti	nez, M.I	., 86	00 01	d_Geo	orgeto	wn_Rd	., Ве	ethesda,	MD 20886
8.	Stat Registra		31. Date filed (Month, Day, Year) DEC 12 2012	37. Registrar	's Signature	artis							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Month Physician/ 12:53 P M Natruskin December Boris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, **Funeral** Director None 1 🛣 M 2 🗆 F 06/07/1930 82 Russia th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Moscow Russia 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 121154 Russia Tukhachevskogo St.32, Building 2, Apt.355 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Jeweler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Natruskin Maria Klochkova Mikhail 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121154 19a. Informant's Name/Relationship (Type, Print) f Health item 27 Tukhachevskogo St.,Building 2,Apt.355,Moscow, Russia Liudmila Paley/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Page 1 permit. Page 1 a
Department of P
Important: If it
any injury or of 1 Burial 2 K Cremation 3 K Removal from State 12/10/2012 Metropolitan Crem. Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licer 10 East Deer Park Dr., Gaithersburg, MD. 20877 Approximate Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Ischemic Stroke Medical resulting in death) Due to (or as a consequence of) Examiner Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Be Completed by

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat. Division of Vital Records, P.O. Box 68760

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	Month Day Year
Part II. Other significant conditions Coronary Artery	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check onl	y one)
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	5 Residence 6 Other (Specify)
27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigati	n (Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
CO. C. Miles 1 M Continue Die	relations. To the heat of my knowledge, death accoursed at the time, date and place, and d	ue to the cause/s) and manner as stated

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

H0057270

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown Road, Bethesda, Maryland 20814 John Kylan Lynch, M.D., 31. Date filed (Month-De

State Registrar

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Medical Certificate:

(Check

only one) 29b. Signature and title of certiffe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month DEC Day 2012 Year OHRI 6:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SANCTUARY AT HOLY CROSS BURTONSVILLE MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country) **Director** 217-94-7846 1 XM 2 □ F 93 MARCH 20,1919 INDIA should be filed within 72 hours efter deeth with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28e-f show eumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No MD. MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14345_STILTON CIRCLE 20905 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Mamied 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: ASIAN INDIAN 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) CLERICAL INDIAN GOV'T. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည treumetic GIAN CHAND OHRI **PURSHOTAM** DEVI BHALLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ai Importent: If item 27 is any injury or other treu DEEPAK OHRI/SON 14345 STILTON CIRCLE, SILVER SPRING, MD. 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State 12-5-2012 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A WWW.M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) g physician and as the burlal yansit or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: esn yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ ٥ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year signed by the a'd be detached for g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, URINARY TRACT INFECTION been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed C. DIFF COLITIS 24a. Was an Were autopsy findings available prior to completion of cause of hes page 2 autopsy performed?
1 ☐ Yes 2 ☒ No After this certificate funeral director, pag 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hin 24 hours after death.

the Funerel Director: Al
πpletely filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2
To the I 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) D0054566 DEC. 4, 2012

State Registrar

DHMH 17 Rev 06-2011

9801 GEORGIA AVE., SUITE 1-17, SILVER SPRING,

MD: 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

BHOGAVILLI,

SUNITHA BHO
31. Date filed (Month, Day, Year)

DEC 05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amended #20b. & 20c. perfuneral home 12/13/2012/ccdh/ba Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 10, 2012 GILBERT HENRY OVERBEY 0515 A M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES RESIDENCE. 2207 WOLF STREET FORT WASHINGTON Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min **Director** 231-36-0799 78 1 🗶 M 2 🗆 F Vrs MARCH 26,1934 VIRGINIA Usual Residence of Decedent 28a-f show 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified MARYLAND PRINCE GEORGES FORT WASHINGTON 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral UNITED STATES 2207 WOLF STREET 20744 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō 1X Never Married 2 Married þ hours after 1 Yes 2 No Specify "natural", Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ndary (0-12) College (1-4 or 5+) 9TH GRADE TRUCK DRIVER TRANSPORTATION Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DANIEL OVERBEY ANNA THOMAS OVERBEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE TERRY-WARREN/ NIECE 4295 NEWBOLD COURT, WOODBRIDGE, VIRGINIA 22192 20b. Place of Disposition (Name of RESURRECTION OF CEMETARY DEC. 14, 2012 HYATTSVILLE, MARYLAND THAT TO THE PARK DEC. 14, 2012 20a. Method of Disposition permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LIDIA C. THORNTON JOHNSON MOO583 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COLON CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or in that initiated events the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months? Month Pregnant at time of death Day Year detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe CAD S/P MI, HTN Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown HYPERCHOLESTEROLEMIA 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? Yes 2 A No certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 X No ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Cofficiency Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Symmer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

only one) 29b. Signature and

31. Date filed (Month, Day, Year)

GILBERT/E. DANIEL, MD

Registrar DHMH 17 Rev 06-2011 ss person who completed cause of death (Item 23a) (Type, Print)

Our tifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MD 035280 DC

1328 SOUTHERN AVENUE, SE, SUITE 205, WASHINGTON, D.C. 20032

29d. Date signed (Month, Day, Year)

DECEMBER 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene 4 U Certificate of Death Registra MEND#5perFH, 12/19/12, BMW, McCo 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dec. 9, 2072 Anneliese Peters 11:08pm 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Friends Nursing Home Sandy Spring Montgomery 7. Age (In yrs, last birthday) 95 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 233 S70 1 22 P6 1 M 2 5 F Hours 7/08/1917 Germany 223-70-221 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State MD Montgomery Silver Spring 1 🗌 Yes 2 🔀 No 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 12417 Palermo Drive 20904 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 😾 No If Yes, Give Year or Dates. 1 ☐ Yes 2x No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hass Gretha unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabine G. Hamidi/daughter 12417 Palermo Drive Silver Spring, Md 20904 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 12/11/2012 Beltsville, Md. Funeral Service (it ense PHTLITP de SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Advanced dementia resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Yes 2 XN 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 \(\sum \) Yes 2 \(\sum \) No X Natural 5 Pending

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

, Lans To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial attending physician use as been signed by the atte should be detached for has page 2 certificate director, within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral director.

Physician/

Medical

Examiner

Funeral

Director

show

ms 23a or 28a-f sho must be notified at

items

"natural",

Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than ury or other traumatic event, the Me

Department of Important: If it any injury or o

Physician/

Medical

Examine

Physician/Medical

β

Completed

Be

Certificate: To

Medical

Accident

Suicide

29b. Signature and title of certifier

4 Homicide

29a. Certifier

(Check only one) Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Examiner

ıral", or iten I Examiner n

the Medical

Director

Funeral

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Completed

Be

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filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

	State
Re	nistrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42699 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 2 Physician/ 0500 AM 2012 Ogan Medical 4a. Facility Name (Unot institution, give street and r 4c. County of Death Examiner Ford Dorchester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1 ♣ M 2 □ F 68 Usual Residence of Decedent maryland 28a-f show 10d. Inside City Limits 10a, State 10b, County 10c. City, Town or Location at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** notified 1 🗌 Yes 2 🎵 No ford 10e. Street and Numbe 10g. Citizen of What Country? 'n pe 23a USA must ! 67 60 items . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Examiner Black, White, etc o þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify. 3 Widowed 4 Divorced "natural", Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working waterma Elementary/Secondary (0-12) College (1-4 or 5+) 2 aterman -employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ -ogan Parks, Sr Wesley Ruark 19a. Informat's Name/Relationship (Type, Pint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Heliport Woolford, Md. 21677 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ☐ Buria! 2 Cremation 3 ☐ Removal from State irect -11-12 Dover Delaware 4 ☐ Donation 5 ☐ Other (Specify) . Signature 22. Name and Ad Jess of Facility Bennie Smith Funeral Home Cambridge Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciany disease or condition resulting in death) a Medical **Examiner** Sequentially list conditions, Due to lor as a consequence of if any leading to immedicause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the at id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has page 2 autopsy performed 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Medical Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 3 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) Mo RS7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 251 Easton an D 2/40 555 ston nwood 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.012/ccdh/ba.
Amended#5perfuneralhome12/18/2012/ccdh/ba.
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:00 PM 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center \$378 = 40 Ny 304 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 1 🗆 M 2 🗘 F Yrs May 23, 1932 Maryland 80 "neturel", or items 23e or 28e-f show ofical Examiner must be putified at 10a. State 10b. County 10c. City, Town or Location within 72 hours efter death with the Maryland Director 10d Inside City Limits 1 Yes 2 No Maryland Calvert. Prince Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A 20678 315 Crescent Ct. #108 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2 XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White 3 Nidowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Waitress Food Service 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is merked other eny Injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John W. Magill. Sr. Mabel E. Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6901 Robinia Rd. Camp Springs, MD 20748 Diana Gritz (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State December 11, 2012 Resurrection Cemetery 4 Donation 5 Other (Specify) Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc. Signature of Funeral Service Licenses 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Drimar Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): signed by the ettending physiclen and id be detached for use es the burial-transit or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ል Completed 1 Tyes 2 2 No 3 Probably 4 Unknown To the Hospitel or Attending Physician: The lew require within 24 hours efter death.

To the Funerel Director: After this certificete has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No ျှ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 12/10/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signati State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Month Physician/ John Allen Robertson, 9:00 P M December 8, 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3114 Gracefield Road, Apt. 517 Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 085-26-1819 **Director** 1 XM 2 □ F 81 June 8, 1931 Washington, DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location aţ Director must be notified 1 Yes 2 KMNo MD Silver Spring Montgomery 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3114 Gracefield Road, Apt. 517 20904 USA or items 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Specify: White 3altimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates. 1951-55 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Data Systems Engineer/Supervisor Telephone traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be filed h and Mental H 7 is marked ot John Allen Robertson, Sr. Frances L. Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Evelyn Lee Robertson/Wife 3114 Gracefield Road, #517, Silver Spring, MD 20904 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12, Dec. Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Suitland, MD . Signature of Funeral Service Licens Francis J. Collins Funeral Home Inc. 500 University Blvd. W,. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Shy Draeger Syndrome disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) B and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death the þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 X No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ပ္ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D37142 December 10, 2012 displeted cause of death (Item 23a) (Type, Print) 1355 Piccard Drive, Rockville, MD 20850 30. Name and address of person who c G. Coleman, MD 31. Date filed OEC 12 2012 2. Registrar's Signature State Registrar

12-09463 Michael D. Roundtree Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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5-0036 led within 72 Hygiene. other than the Medical	ם	12 Gardener Landsc										,
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212 uld buld by Ment mark	70	19a. Informant's Name/Relationsh			19b. Mailing	Address (Stree				per, City or Town	, State, Zip	Code)
MD 21215-0036 1.2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 1.27 is marked other than "natural", or items 23s or 28s-f shumatic event, the Medical Examiner must be positifed at once		Robyn M. Round	tree / Moth	er	9341	Lanham S	Severn	Roa	d, Lan	ham, MD	20706	5
nore, MD 2121; ages 1 and 2 should be file nt of Health and Mental It: If item 27 is marked other traumatic event,	ш	20a. Method of Disposition				tion (Name of ce	metery,	D	ate	20c. Location - 0	City or Tow	n, State
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other traumatic event, the Med	ш	21. Signature of Funer lice I		00956	T	hibadeau'	1 Mort	uary	Servi	ce, p.a.		
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Divi	Certification:	4 Homicide determ	mined (Specify)									
		29a Certifier 1 Certifying Ph	ysician: To the best of m	y knowledg	e, death occur	red at the time, d	ate and plac	e, and due	e to the cause	e(s) and manner	as stated	(-)
To the How within 24 h To the Fun	Medical	one) 2 Medical Exam	niner:On the basis of exa and manner stated.	mination an	id/or investigati	ion, in my opinior	i, death occi	urred at th	e time, date a	ind place, and du	e to the ca	use(s)
H 3 H 2	ž	29b. Signature and title of certifier				29c. Licens	e number			29d. Date signe	d (Month, i	Day, Year)
		D-201.				O.C.	M.E.			December 1	13, 2012	
		30. Name and address of person	who completed cause of c	leath (Item 2	23 a)							
		Donna M. Vincenti, MD	Assistant Medic	cal Exam		W. Baltimore	Street, E	Baltimor	re, MD 212	223		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death												
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and Heal	ther		20a. Method of Disposition	app (apo		Place of Dispos		i i	Date Date	20c. Location -		
age 1	y or		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State	cemetery, crem	natory`or other plac					
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al or safe	i d		4 🗆 Homicide determi		ing, etc. (Specif				City or Town			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director, After this certificate has been stoned by the attending physician and	ed fille	ledical		Physician: To the b								
the Hi nin 24 the Fu	nplete	Med	only one) 3 Certifying	Nurse Practioner:								se(s) and manner stated. ited.
To t	10	**	29b. Signature and title of certifier	X. D	A -	*	29c. License	number	2	29d. Date signed	(Month, D	ay, Year)
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_			30. Name and address of person v		,				DC CC	007		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 42704 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 28, 2012 14:55 P.M Charles William Russell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 578-46-6391 Dec. 29, 1935 Director Washington, DC 1 X M 2 □ F 76 than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland Silver Spring Montgomery 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2900 Memory Lane 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed Specify: Black 3 Widowed 4 Divorced If Yes, Give Year or Dates 1954-1957 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Fducation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) Rosalee Russell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8758 Raven Glass Way Montgomery Village, MD 20886 Nicole Drummond -Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Caretery 12/7/2012 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death Cardiac disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer Sibrillation ventricular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit torsades that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ₩ No ဥ Other: 1 Supplient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and Certifying Nusse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 104 0061386 November 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 20850 John MD 9901 Medical Cd 31. Date filed (Month, Day, Year) State 05 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 2 1 - For State 23a, 12/7/12, rs Registrar Amended Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER Day 3 Physician/ 2012 1230 M LEE F. ROSE, SR. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TALBOT MEMORIAL 1 tOSPITAL EASTON Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Days Hours 212-40-7634 1 🛣 M 2 □ F Director MARYLAND 69 01/14/1943 th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 ☐ Yes 2 🗶 No **TALBOT EASTON** MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 10362 OLD CORDOVA RD. 21601 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. <u>۾</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BEVERAGE SALES REPRESENTATIVE Be Page 1 and 2 should be filed ment of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MILDRED FAULKNER CHARLES ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10362 OLD CORDOVA RD. EASTON, MD 21601 ANN ROSE / WIFE permit. Page 1 and 2: Department of Health Important: If item 27 any Injury or other troones. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other park) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 12/10/2012 | EASTON, MD 21. Signature of Funeral Service Licensee FETALOWSAGONHECKEENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Intracranial Bleeding Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Intracania bleeding Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury Hospital or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ ibrillation 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Natural 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my spirited death. Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signatule and title of certifier d address of person who completed cause of death (Item 23a) (Type, Print) ST 50 Ven 219 S. WASHINGTON State Registrar

State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOSEPH BARTHOLOMEW ROMEO 2012 2:45 PM Medical Dec 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare -The Pines Talbot Easton 5. Social Security Number Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth Days Months OCT Day Hours Min. 252-52-3083 80 **Director 1**932 PENNSYLVANIA Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD **TALBOT** EASTON 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28271 OAKLANDS ROAD 21601 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give WHITE 3 Divorced Specify: Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) LIEUTENANT COLONEL UNITED STATES AIRFORCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ THOMAS MOSERA SUE CIONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE MARIE ROMEO, WIFE 28271 OAKLANDS ROAD, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION! 12/11/2012 STEVENSVILLE, MD of Fu 21. Signa ELTOWS THE FEW BEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part 1. Enter the disease, or complications that clused shock, or heart failure. List only one cause on each line used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine 1. carsician and burial-trans resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) မ 1 Tes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 🗌 Yes 2 🗌 No filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 ho

To the Fune (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12.10.12 Name and address of person who completed cause of death (Item 25a) (Type, Print) 610 ROWLEY MD DUTCHMIANS RS 6+1VA State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Romeo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 12-8-2012 Physician/ 7:45 a M Shah Begum Said Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1-25-1938 Days Hours Pakistan 579-04-8953 74 Director 1 M 2 K F Usual Residence of Decedent 10d. Inside City Limits er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b, County filed within 72 hours after death with the Maryland Director Silver Spring 1 X Yes 2 ☐ No Md. Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 3400 Marrell St. Funeral Pakistan Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Black, White, etc. Armed Forces? Completed by 1 Yes 2X No 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Asian 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker permit. Page 1 and 2 should be filed wit.
Department of Health and Mental Hygier Important: If item 27 is marked other t. any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shah Balgees မ Shah Gazan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3400 Marrell St.Silver Spring, Md. Saghir Shah-Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Adelphi, Maryland 1 X Burial 2 Cremation 3 Removal from State 12-9-12 Geo. Wash. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 411 kennedy st, n.W. 21. Signature of uneral Service Licenses Universal Mortuary Inc, Washington, D.C. 20011 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure Acute disease or condition Medical resulting in death) Due to (or as a consequence of) [']Examiner Severe Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consuquence of -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> Division of Vital Records. 1 Tes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **K**] No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) å Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License numbe 12-8-12 D0073240

State Registrar

DHMH 17 Rev 06-2011

1500 Forest Glen Rd, Silver Spring, Md.

20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Anisha Kumar, M.D.

DEC 1 2 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 Day C Physician/ ZOIZ Robert Lee Shockley, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HICAMICO RIGIONAL SALISBURG TENINSULA Centu If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Days (Month, Day, Year) Director 220-34-9910 1 🛛 M 2 □ F 73 Dec. 18. 1938 Maryland 10d. Inside City Limits other than "natural", or items 23e or 28a-f aho vent, the Medical Examiner must be natified at 10a, State 10b County 10c, City, Town or Location Director 1 Yes 2 X No. Snow Hill MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21863 6905 Scotland Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, or it Black, White, etc. Yes 2 No δ 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) E.S. Adkins Company 8th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should ba file and Mental F merked မ Mildred Duffy Clifton Shockley, Sr. Department of Health and Important: If item 27 is m any injury or other treumvonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6905 Scotland Road - Snow Hill, Maryland 21863 Edith Shockley / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 12/15/2012 Snow Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Wesley UMC Cemetery 21. Sign ture of Funeral Service Licens 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ENCEDHALO ase or condition Medical resulting in death) Examiner 20 HUURI Sequentially list conditions, Due to (or as a consequence of): If any, leading to immediate cause. Enter Underlying Cause (Disease or injury 20 HOURI ettanding physiclen and for use as the burlei-transit To the Hospital or Attending Physician: The law raquires thet tha daath certificate be axecuted within 24 hours aftar death.

To the Funarai Director: After this certificate has baen signad by tha ettanding physicien and completely filled in by tha funaral diractor, paga 2 should be datached for use as the burlel-transl Exam that initiated events resulting in death) Last Physician/Medical 45181 07V5202 Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy cerformed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Ale of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-22132 12-8-12

State

Registrar

OHMH 17 Rev 06-2011

560 RIVORIDGOR- B-ZOY, SACISBURY, MD Z18 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E-BIRDUD

Coay, Year) 2 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shirley Scharpf Neal 2013 Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Dic Sburl 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav. **Funeral** 1 □ M 2 🕱 F Months (Month, Day, Year) 05/08/193] 214-28-1983 81 Director Marvland Usual Residence of Decedent 28a-f show 10b. County 10c City Town or Location 10d. Inside City Limits 10a. State Director must be notified Salisbury 1 🗌 Yes 2 🄀 No Wicomico Maryland 10f. Zip Code 10g. Citizen of What Country? 0 10e. Street and Number items 23a Funeral USA 21804 910 James Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Force Black, White, etc. and Mental Hygiene. is marked other than "natural", or i þ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland (21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life_DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Office Manager 12 permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maude Kinnamon ည Raymond Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Horsetail Court, Fruitland, MD 21826 Douglas Nolan/Friend 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/11/2012 Salisbury, MD Wicomico Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ovan Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and tran Due to (or as a consequence of): sician a Physician/Medical requires that the death certificate be Box 68760 attending physi IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery Ectopic pregnancy in the past 12 months? Month Other (specify) Pregnant at time of death Unknown P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perfor 1 Yes this certificate Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifica Division of Vital funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence Other (Specify) ၉ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending injury 2 🗆 No Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 0 63 199 29b. Signature and title of ce

Registrar

DHMH 17 Rev 7/2009

State

Name and

SHORE DR. SALISBURY,

who completed cause of death (Item 23a) (Type, Print)

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	Examin	ier	4a. Facility Name (if							, Town, or		of Death			c. County			
	Funeral		5. Social Security Nu		L HOSPIT		yrs. last birti	hday)	If Unde		If Under		8. Date of I	Birth	WORCE	9. Birthp	lace (State or F	Foreign
5.	Director ≥		217-70-5 Usual Residence o	f Decedent	1 □ M 2 🛣 F	71		Yrs.	Months	Days	Hours	Min.	(Month, MARCH		1	JNITE:	D KINGD	MO
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	with the s 23a of ust be	Funeral Director	13512 C	HOLLY	LANE					21842				_	SA		,.	
920	72 hours after death with the Maryland n"natural", or items 23a or 28a-f sho fedical Examiner must be notified at	10e. Street and Number 10f. Zip Code 10g. Citizen of Wh 10g. Ci											k, White,					
5-0	2 hour "natur edical	plete	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Bu											usiness/Ind	dustry			
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Baltimore,	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 ☐ 4 ☐ Donation	f X Cremation $$	Removal from	State	cemeter	y, crem	atory or c	other place					LMAR,	-		
Balt	permit, Page Department of Important: If any injury or once.		21. Signay re of Fur	1. Signal re of Furieral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVII													10075	
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P	tiyacian/		Immediate Cause (F disease or condition	Final	ny one cause on ea	SeD.	ficen	n a	•								Interval Betwe Onset and Dea	
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. Box 68760	to the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?		Birth 2 [nant at tim	oregnancy I Fetal death ne of death		Ectopic Other (s)		У				23d. Dat Mor	te of delive	ry Day Yea	ar
P.O.	s that the gned by be deta	ğ	Part II. Other signifi	cant condition	s contributing to d	eath but n	ot resulting in	n the u	nderlying	cause giv	en in Part	:1.	1				e cause of deat	
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Division of Vital Records,	In the Hospital or Attending Physician: whe Flowers after death. To the Tuneral Director: After this certifica completely filled in by the funeral director,	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ot be 28e. Place	of Injury - ng, etc. (S _i	At home, far pecify)	m, stre	et, factor	y, office				(Street a		er or Rural	Route Number,	
۵	spital of spital		29a. Certifier 1	Certifying F	hysician: To the b	est of my	knowledge, o	death o	ccurred a	it the time	, date and	d place, a	nd due to the	cause(s)	and mann	er as state	ed.	
:	the Ho nin 24 h the Fu npletel	Medical	(Check 2' only one) 3	☐ Medical Ex.☐ Certifying N	aminer: On the bas lurse Practitioner	sis of exam	ination and/o	r invest	gation, in	my opinio	n, death o	ccurred at	t the time, date	e and plac	e, and due	to the cau	se(s) and manne	er stated.
	70 VIII		29b. Signature and t	itle of certifier						c. License		2 -		29d. D	ate signed	(Month, E	Day, Year)	
	DIC		30. Name and and	ss of person wi	no completed caus	e of death	n (Item 23a) (1	Type, P		DUC	641	40			2/6	1 201		
			Atit	zeerh	an Aq	H 9-	733		alth	Way	Dn	ive	Berli	'u	MID	21	811.	
	Stat Registra		31. Date filed (Month	Day, Year)	2012	egistrar's	Signature	Sa	Mal	, '								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Smith Margaret December 2012 19:40 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Wicomico 35858 Purnell Crossing Pittsville Road If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XF Months Days Hours 4-22-1926 Maryland 213-60-8906 86 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Pittsville Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21850 35858 Purnell Crossing Road 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 2 Yes 2 X No 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give Year or Dates Completed 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Poultry Grower 9 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown ပ Jackson Florence **Garland** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35858 Purnell Crossing Road, Pittsville, MD 21850 Mary E. Smith - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12-18-2012 Libertytown, MD Riverside Cemetery 4 Donation 5 Other (Specify) Bounds Funeral Home 21. Signature of uneral Service Licenses 22. Name and Address of Facility 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only only frons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ Acute disease or condition resulting in death) CONCHURS Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burla-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death ate has been signed by the a page 2 should be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Chacrice Renel discess 24a. Was an performed 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

only one) 29b. Signature and title of certifie

31. Date filed (Month, Pay,

Cly de Erreit Got & m. 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Exuest Gibb , JR M. 8

32 Registrar's Signatur

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		_	For	State of M									_	oie.		
		_	1 - State Registrar Certificate of Death Reg. No. 20 2											2	42712	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Thomas Albert Spear Jr.						2. Date of Death Month C 2 mber					/ear	3. Time of Death	
	Examin	er	4a. Facility Name (if not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTU				4b. City, Town, or Location of Death SALISBURY					4c. County of Death . **NICOMICO**				
	Funeral Director		216-48-5808			Months Days			If Under Hours	If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day,)			9. Birthplace (State or Foreign Country)			
			Usual Residence of Decedent	1 X IM 2 LIF	62	Yrs.					12/16/	1949	19 Maryland			
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Importent: If Item 27 is marked other than "neturel", or items 23e or 28a-f show any Injury or other traumatic event, the Medical Ex. miner must be notified at once.	tor	10a. State 10b. County		10c. Cit	y, Town or Lo								10	d. Inside City Limits	
		Funeral Director	Maryland Wicomico Salisbury 1 Maryland Number 10f. Zip Code 10g. Citizen of What Country?											1 🖾 Yes 2 🗌 No		
		eral	1308 N. Division St.					21801						at Countr	у?	
		Fun	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S		Was Decedent of Hispanic Origin? (Spot If Yes, specify Cuban, Mexican, Puerto				fy Yes or No-		14. Race - American Indian,			
36		d b	1 Never Married 2 Married 1 X Yes 2 If Yes, Give			No		1 ☐ Yes 2 🛣 No Specify:					Black, White, etc.			
8		letec	15. Decedent's	Education	Cuar		16a. Decedent's Usual Occupation 16b							White Kind of Business/Industry		
215		Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4 or	5+)	(Give kind of work done during most of wor life. DO NOT use retired)					7					
121		as I	12 –				owing Operator						Towing Company			
anc		일	17. Father's Name (First, Middle, Last) Thomas Albert Spear Sr.				18. Mother's Name (First, N Patricia V									
Maryland 21215-0036			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat								te, Zip Co	ode)				
e,			Ryan A. Spear/Sc				position (Name of				ate	c. Location - City or Town, State				
Baltimore,			1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	emetery, crer	matory or other place)											
alti			21. Signature of Funeral Service Licensee 22. Name and Address of Facility													
8			Holloway Funeral Home Professional Associati											ociation		
	rnysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. Due to (or as nonsequence of):													
	law requires that the death certificate be executed has been signed by the attending physician end e 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	uence of):												
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. Box 6876(nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										23d. Date of delivery Month Day Year			
P.0		by PI	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										use contrib	e contribute to the cause of death?		
ds,		Completed by Physician/Medical									1 🗆	Yes 2	2 No 3 Probably 4 Dunknown			
eco.	he law re te has be age 2 sh										24a. Was auto perfo	psy prmed?	24b. Were autopsy findings available prior to completion of cause of death? No 1			
E	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2										1 Yes 2 No 1 Yes 2 No No No Yes 2 No Yes 2 No No Yes 2 Yes 2 No Yes 2 Yes 2 No Yes 2 Y					
f		욛	1 Yes 2 No		1 Annatient 2 ER/Outpatient 3 DOA 4 Nursi						ng Home 5 Residence 6 Other (Specify)					
0		cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigati	28a. Date of injury 28b. Time of injury injury				28c. Injury at work? M 1 ☐ Yes 2 ☐ No			28d. Describe how injury occurred					
Division of Vital Records,		Medical Certificate:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	Hosp 24 hou Funer etely fil		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
	To the within To the compl		29b. Signature and title of contifer 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)													
0	101 1 2 1 2 1 2 1 4 9									94	4 December 11, 2012					
	VAI HB		30. Name and address of person who	completed cause of c	leath (Item	23a) (Type, F	Print)	151	SA	(1864	y m	9	21801			
	Stat Registra	- 1	31. Date filed (Month, Day, Year)	2012 32. Registr	ar's Signat	ture A.	bark									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Patricia Ann Scribner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Alcon 100 ROJOVAL Center 544136414 PENINSULA 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days **Director** 230-54-4895 1 □ M 2 🖾 F 70 May 2, 1942 Maryland i Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 🗌 Yes 2 🔀 No Wicomico Parsonsburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21849 32974 Gadwall Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give à 1 Never Married 2 X Married 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 and 2 should be filed with if Health and Mental Hygien item 27 is marked other the homemaker home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Miriam Gibbs Norman Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21849 Rodriquez Wilkinson (Brother) 32974 Gadwall Lane Parsonsburg, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 12-10-2012 Delmar, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Whert Delmar, DE 13 E. Grove Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a sequence of) Examiner Sequentially list conditions, Due to (or a a consequence of): if any, leading to immediate cause. Enter Underlying Exami sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending physic IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de à Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No မှ the Funeral Director: After well-stely filled in by the funeral directors. 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

68760 Box (Records, **Division of Vital** npletely

Baltimore, Maryland 21215-0036

State Registrar

270

29b. Signature and title of certifier

30. Name and address of pe

STAVANTA

31. Date filed (Morn)

100

on who completed cause of death (Item 23a) (Type, Print)

MD

PATAPAKA

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

E. CARROLL ST. SALISBURY MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBERDAY Physician/ Stoker 2012 Helen Louise 2350 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Memorial Hospital at Easton TALBOT Easton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/19/1915 Birthplace (State or Foreign Country) **Funeral** Days Hours 97 Director 220-03-4915 1 □ M 2 □ F MD. Usual Residence of Decedent permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Importent: If item 27 is merked other then "natural", or items 23a or 28e-f show eny hjury or other treumetic event, the Marian Experient Treather notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct MD. Talbot Claiborne 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral U.S.A 23328 Cockey Road 21624 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3

Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Health Care College (1-4 or 5+) Practical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter Harrison Daisy Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley S. Cockey/ Daughter 23328 Cockey RD. Claiborne, MD 21624 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delmar, DE. Crem. of Delmarva 12-11-12 21. Signature of Funeral Service License Hurrey Adams Ostrowski Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Michaels. 21663 Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Priysician Bowe OBSTRUCTIO Small 10 day Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and dbe detached for use es the burial-transit To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed^a 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Forth 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 d Hatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29c. License numbe 29d, Date signed (Month, Day, Year, 7 ndh who completed cause of death (Item 23a) (Type, Print) LS3 seder M.D 503 Cynwood Dr. Easton MD 31. Date filed (Morp PO 1a State

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 7, JANE HILL SAVINGTON 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WILLIAM HILL MANOR EASTON **TALBOT** Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Director 90 VIRGINIA 214-12-6471 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits Directo MD **TALBOT** 1 Yes 2 No **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 DUKES AVENUE 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY BUSINESS SYSTEMS Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) GROTON THOMAS HILL HILDA E. MUMFORD and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau LYNN R. THOMAS, GRANDDAUGHTER 8698 SKYVIEW, EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PK | 12/14/2012 EASTON, MARYLAND 21. Signature of Funeral FELLOWS: HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MP 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on ea Immediate Cause (Final Onset and Death Physician/ ISCHEMIL CARDIOMYOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARDIOVASCUME ATHEROSCUR OTIC Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ysician and e burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical phys IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown the s 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, IN SUFFICIENCY, HYDRICIPIDEMIA HYPRITEUSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an autopsy performed Yes 2 2 **N**O **Division of Vital** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Tes 1 Inpatient 2 I ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft d in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined filled in City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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State Registrar SLOOM IN CDAUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 SAUOY 15 A OSe 2012 10: Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death hesapea Dhores exina 10 Under 24 Hrs. Social Security Numbe 9. Birthplace Country) 7. Age (In yrs. las (irthday) If Under 1 Year 8. Date of Birth **Funeral** (Month, Day, Months 1 ▼ M 2 □ F 213-22-0253 86 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MazylAnd Alton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 9300 Bel 20611 U SA w-to-u-12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Black Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12-MICH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ rocto 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd Bel Alto SAUOY 20611 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other 12-18-12 MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service License any 20608 23a. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Deat shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) MON Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is interested as a condition of the condition Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? after death.

Director: After this certificate Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier Dec 10, 2012 Imman

BO State

Registrar

GREAT MILLS ROAD

and address of person who completed cause of death (Item 23a) (Type, Print)

2 2012

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2³/₂, 2012 6:00 P Evelyn Louise Shears November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Manor Care Nursing Home Chevy Chase Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 579-09-8563 Director 1 M 2 X F DC Nov. 20, 1914 98 Usual Residence of Dece at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 🖺 Yes 2 🗆 No Maryland Chevy Chase Montgomery 10e. Street and Numbe 5 10f. Zip Code 10g. Citizen of What Country? 23aFuneral 20815 United States 8900 Jones Mill Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 0 þ 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black "natural", 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Government Be 17. Father's Name (First, Middle, Last, 18, Mother's Name (First, Middle, Maiden Surname) မ Madge Brooks Wallace Broadus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other transons. Upper Marlboro, MD Joyce Hunter - Niece 0 Box 4663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dec. Date1, 1 M Burial 2 Cremation 3 Removal from State Suitland, Maryland 2012 Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Stewar Sohn T. Washington, DC 4001 Benning Road NE M00560 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final 5 mon Cath Physician disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of): **Examiner** years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) requires that the death certificate be executed years Cardiomyopathy physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown Unknown ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 Jas autopsy performed? Yes 2 No death? certificate 2 🗌 No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital 1 Yes 2 X No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 $\[\]$ Nursing Home 5 $\[\]$ Residence 6 $\[\]$ Other (Specify) this funeral 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: After t 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) December 4, 2012 30. Name and address of person who con pleted cause of death (Item 23a) (Type, Print) 15:1 10810 Darnestown Rd. Ste. 202 Raman Tuli, M.D. Gaithersburg, MD 20878 2. Registrar's Signature State Registrar

State Registrar

DHMH 17 Rev 1/2001 11595

Baltimore, Maryland 21215-0036

68760,

Box

P.0.

Records,

Division of Vital

D67067

December 9 2012

4940 Eastern Avenue, Baltimore, MD, 21224

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

31. Date filed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ UVENCE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 610-20-1771 Director 1 M 2 □ F March 5,1953 Yrs Salvador Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show well july or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 El Salvador 2629 NORTHSHIRE DR 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 No Specify: Specify: Hispanic Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Construction, Co 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gregoria de Jesus Valencia ပ UNKNOWN 19a. Informant's Name/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria del Carmen Valencia 2629 Northshire DR Baltimore City, 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/8/2012 Silver Spring, MD Heaven 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Santa Cruz Funeral Services, Inc **MO1421** 600 Kennedy St, NW.Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) nterstitic Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit the attending physician and the for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 戸 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 W Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Means St Baltimore 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201^{rea} Edna Widger December 7:30 P M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3516 John Carroll Drive 01ney Montgomery Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Hours Min **Director** 118-30-6296 1 🗆 M 2 🗓 F 74 04/26/1938 New York 28a-f show "natural", or Items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3516 John Carroll Drive 20832 United States be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 2 X No Baltimore, Maryland 21215-0036 ☐ Yes 1 Yes 2 No Specify: If Yes, Give Completed 3 Divorced Year or Dates White Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur jury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Foster Fanny Kryger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry L. Widger/Spouse 3516 John Carroll Drive, Olney, Maryland 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 12/14/2012 | Rockville, Maryland Parklawn Mem. Park 21 Signature of Funeral Service Licen 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician Metastatic Pancreatic Cancer months disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and for use as the burid train Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the IF FEMALE: asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ctopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death ed by the a 9 Unknown Unknown Division of Vital Records, P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe After this certificate Yes 2 X No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Tes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar nd title of certi

Pamela Seam, M.D., 31. Date filed (Month, Day, Year)

DEC

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature

DHMH 17 Rev 06-2011

MD.

29c. License numbe

655 Watkins Mill Road, Gaithersburg, Maryland 20879

D 70789

29d. Date signed (Month, Day, Year)

December 11, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Depa	rtment of Health and N	Mental Hygiene
				tificate of Death	Reg. No.2012 42721
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
	Medic	al	Marguerite M. Weaver 4a. Facility Name (if not institution, give street and number)		December 8, 2012 8:20 A M
	Examin	er	, , , , , , , , , , , , , , , , , , , ,	4b. City, Town, or Location of Death	4c. County of Death
	Funeral		Warm Heart Assisted Living	Germantown If Under 1 Year If Under 24 Hrs.	Montgomery
	Director		045-12-8948 1 □ M 2 🖾 F Yrs.	Months Days Hours Min.	(Month, Day, Year) Country)
	d d	<u>.</u>	Usual Residence of Decedent 89 10a. State 10b. County 10c. City, Town or Loc	ation	08/24/1923 Connecticut
	arylar a-fsh fied a	ecto			1 ☒ Yes 2 ☐ No
	or 28 e noti	Dir	Maryland Montgomery Gaither 10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	Funeral Director	705 Linslade Street	20878	United States
	death item ner m		11. Marital Status 12. Was Decedent Ever in U.S. 13. Warned Forces?	/as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
36	after al", or xami	d by	1 Never Married 2 Married 1 Yes 2 X No	☐ Yes 2 🕱 No Specify:	Specify'
Š	hours natura ical E	Completed	15. Decedent's Education 16a. Decede	ent's Usual Occupation	16b. Kind of Business/Industry
215	n 72 e. nan "r Med	dmo		ind of work done during most of work NOT use retired)	ing Total tall of Dealited, Mades,
21	ygiene ygiene her th		8 Ho	omemaker	Home
and	e filec ntal H ed ot	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maiden Surname)
Maryland 21215-0036	ould be mark		Joseph Little 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing		Sarah Whelehan
Σ	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mertal Hygiene. The marked other than "ratural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at				al Route Number, City or Town, State, Zip Code) aithersburg, Maryland 20878
Ē,	1 and of Hea item		20a. Method of Disposition 20b. Place of Dispos	sition (Name of	Date 20c. Location - City or Town, State
E E	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 【 Cremation 3 【 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropol1	tan Crem. 12/1	1/2012 Alexandria, Virginia
Baltimore,	permit. Page Department Important: b any injury or once.	-	21 Signature of Funeral Service Licensee 22.	Name and Address of Facility DeV	ol Funeral Home
					or., Gaithersburg, MD. 20877
	-0.001010000		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final	r the mode of dying, such as cardiac o	or respiratory arrest, Approximate Interval Between Onset and Death
	Medical	e i	disease or condition resulting in death) Lunz Cancer Due to (or as a consequence of):		Onder and Beath
	Examiner				
	PAGE.	Examiner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying		
	onted nd	xam	Cause (Usease or injury that initiated events C.		
	cian a	dical E	resulting in death) Last Due to (or as a consequence of):		
09/89	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriations!	edic	d		
8	certifii nding use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
Rox	death e atte ed for	Physician/Med	1 Yes 2 X No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month Day Year
	t the c by th stache	Phys	9 Unknown		
<u>7.</u>	law requires that the nas been signed by the e 2 should be detach	by	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🎛 No 3 ☐ Probably 4 ☐ Unknown
rds	requir been s should	etec			
Records,	sician; The law r certificate has b lirector, page 2 s	Completed			24a. Was an autopsy findings available prior to completion of cause of death?
<u> </u>	in; The lificate h tor, page		25. Was case referred to medical	26. Place of Death (Check	1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 ☐ No
Vital	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	Other:	ome 5 Residence 6 X Other (Specify) Living
ō	ng Ph fter th ineral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how injury occurred
Ö	ttendi death. tor: A the fi	Certificate:	2 Accident Investigation	M 1 🗆 Yes 2 🗆 No	
Division of	after a	Cer	4 Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)	et, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	spital hours neral y fillec	ical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death or	ccurred at the time, date and place, ar	nd due to the cause(s) and manner as stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigned only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, or the best of		
	To to to		29b. Signature and title of celtifier	29c. License number	29d. Date signed (Month, Day, Year)
	τ		(ble VV)	D 37142	December 11, 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type, Pr Geoffrey Coleman, M.D., 1355 Piccard		Pockwille Maryland 20850
	Stat	e	31. Date filed (Month, Day, Year) 22. Registrar's Signature	January Durice 100,	MOCKVIIIE, Maryland 20030
¥	Registra		31. Date filed (Month, Day, Year) DEC 12 2012 DEC 12 2012 DEC 12 2012		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 9, 2012 Physician/ 4:35 Margaret Cecilia Ward PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 01ney Medstar Montgomery Medical Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** (Month, Day, Year) Director 216-70-7616 55 1 □ M 2 🖾 F Feb. 9, 1957 Washington, DC permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23e or 28e-f other traumatic event, the Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 1 No MD Howard Fulton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA Funeral 20759 11379 Iager Blvd. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by White 1 ☐ Yes 2 ¥☐ No Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Rosary Beads 12 Rosary Maker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Brand Margaret Cecilia John Lawrence Ward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $4304\ Mt.\ 01ney\ Lane,\ 01ney,\ MD\ 20832$ 19a. Informant's Name/Relationship (Type, Print) Patrick Anthony Ward/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 13, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dec. Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 2012 21. Signature Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine signed by the attending physician and idea betached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementos 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' After this certificate 1 Yes 2 No 8 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No |은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death
To the Funerel Director: A
completely filled in by the f 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 Wakefield June Dec.11 4:00a Shirley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens Prince George's Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** Days Hours Min 8/31/1921 200-05-5250 Director 1 M 2 X F Pennsylvania 91 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a, State 10c. City, Town or Location Director 1 🗌 Yes 2 🎦 No Gaithersburg MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20878 976 Featherstone Street 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna M. Kuhlmann Howard D. Osborne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2087819a. Informant's Name/Relationship (Type, Print) James H.Wakefield/Son 976 Featherstone Street Gaithersburg, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Chesapeake Crem. 12/12/2012 Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Juneral Service Libens PHTLTP^{ddps:}於TWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 5yrs 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Chronic obstructive pulmonary disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the build registrates. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown hypertension Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2. prior to completion of cause of death? 1 🗌 Yes 2 🗆 No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2**₹** No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, gleath occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

30. Name and address of pers

31. Date filed (Month, Day, Year)

Eileen Gemmell

completed cause of death (Item 23a) (Type, Print)

62. Registrar's Signature

CRNP.

29d. Date signed #

3100 Gracefield Rd. Silver Spring, Md 20904

Aonth, Dav. Year)

Registrar

DHMH 17 Rev 06-2011

State

Cherry Lane, Suite 211

Laurel, MD 20708

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pri+am S. Saini, MD 9101 Cherry L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg No 2 0 2 4 2 7 2 5											
			Registrar 1. Decedent's Name (First, Middle,	Last)	(Certificate of	Death	T	neg. neg.				
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	Examin		4a. Facility Name (if not institution,			4b. City, Town,	or Location of De	eath	4c. County of Death				
	/	Щ	TENINGULA REGIO 5. Social Security Number		ge (In yrs. last birthda	If Under 1 Yea	3A4/34		MICON				
ı	Funeral Director		220-32-2145	1 □ M 2 🗓 F	75 Yrs	Months Days		Min. (Month, Day	(, Year)				
	bow th	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location		4-4-19	3/	Maryland 10d. Inside City Limits			
	herylar Be-f si	ectc	MD Wico	mico		bron				1 Yes 2X No			
	e or 2	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?			
	th with	ner	27247 Crooked O		5		21830		US				
ယ	or iter	by Fu	11. Marital Status 1 ☐ Never Married 2 【XMarri	12. Was Decedent Armed Forces ed 1 \(\text{Yes} \) Yes 2 \(\text{Yes} \)	Ever in U.S. ? X No	 Was Decedent of If Yes, specify Cul 	Hispanic Origin? ban, Mexican, Pu	' (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, Wh	merican Indian, hite, etc.			
21215-0036	filed within 72 hours after death with the Meryland al Hyglene. al Hyglene. d other then "neturel", or items 23e or 28e-f sho event, the Medical Evaminar must be notified at	ted t	3 🗆 Widowed 4 🗀 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 💢 N	lo Specify:		Specify:	White			
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Baltimore,	of Her of Her if Item ir othe		20a. Method of Disposition 1 Burial 2 Cremation	2		sposition (Name of crematory or other pl	ace)	Date	20c. Location - City	or Town, State			
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.89	certific anding use as	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2 Fetal death	۰۵۰۰			23d. Date of	delivery			
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Division of Vital Records,	w request passion of the second secon	Completed						24a. Was a		autopsy findings available			
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	TO		30. Name and address of person w	the completed sauce of	death (Item 22a) (T:	e Print)	430 13		12 181	2012 ld MD 21817			
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 6:58A M ANNA MAE WHITBY Dec **2019** Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital Easton Memorial Talbot 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth **Funeral** 213-22-5195 Days (Month, Day, Year) 06-02-1925 Hours Min. 87 Director 1 M 2 X Yrs MD. Department of Health and Mental Hygiene. Important, or items 23a or 28a-f show Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modeal Examiner must be notified at any injury or other traumatic event, the Modeal Examiner must be notified at another. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 610 Dutchmans Lane 21601 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Anna Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ XNo Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Retail Store Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk 10 -0-Whitby, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Anna L. Wesley W. Parks Harry Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 316 Sycamore Ave. Easton, MD. 21601 Paul Haddaway/ Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Easton, MD. Woodlawn Mem. Pk. 12-8-12 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²Hurleydræ o'Ósitrowski Funeral Home P.A. Ustwush: Joseph M. P.O. Box 518 St. Michaels, 21663 MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary disease or condition was Medical resulting in death) Examiner Hypertusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir within 24 hours after death. **To the Funeral Director: After t**his certificate has been signed by the attending physician and compietely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown vascular discase, CHIF, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No BCC OB Rt forearm, 1 Yes 2 No SP WIC 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 Dutchmanska Easton

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ _р М DELOIS WOODRUFF 12-5-2012 2:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. THOMAS MORE NURSING HOME HYATTSVILLE Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days (Month, Day, Year) Months Hours Min. Country) 422-54-7894 1 ☐ M 2X 73 AL MAY 25,1939 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD PGSUITLAND 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 2813 CRESTWICK PLACE 20748 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify:BLACK Completed Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER PRIVATE 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN NEAL WILLIAMS BESSIE MAE PORTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS WOODRUFF III/SON 11719 BUTLER BRANCH RD, CLINTON, MD 20735 or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State -8-2013 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON, VA injury (ARLINGTON CEMETERY 21. Signature of Funeral Service Licensee 22, Name and Address of Facility POPE FUNERAL HOMES, P.A. 'n 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 WALES 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ Alberrallerotic ardiovas cular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) physician and s the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last executed Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ où lu 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate ha performed Yes 2 1 ☐ Yes 2 ✓ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this or
d in by the funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 0063681 12 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hyaltsville MD as Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month 659 A M Adams 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of Manyland Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 245-42-3025 1 🔀 M 2 🗆 F 1933 North Carolina July 17, 79 or then "neture", or items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Forest Hill Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21050 2408 Dixie Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) el Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Adjuster Insurance permit. Page 1 end 2 should be filed witl Department of Health end Mentel Hygier Importent: If Item 27 is marked other ti eny injury or other treumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Sallie Baker Osborne William Abner Adams Jr. 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2408 Dixie Lane, Forest Hill, MD 21050 Barbara Rowland Adams / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Rose Hill Sycs, LLC 1-1-2013 Bel Air, Maryland . Signature of Fun 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final onaestive Heart Physician. disease or condition Medical resulting in death) Due to for as a consequence of Examiner occurdial Sequentially list conditions, Examine Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events anding physician end use as the burlei-trensit The law requires thet the death certificate be executed pronun Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physicien: The law requires thet the beam beam beam of within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician of the Funeral Director: After this certificate has been signed by the ettending physician completely filled in by the funeral director, page 2 should be detached for use as the burlet Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012

State Regist<u>rar</u> South Greene Street Baltimore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signature

Schrenk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 2012 12:45 p M Donald Leslie Ault Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Knoxville Washington 18926 Sandy Hook Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Hours Min. Jan 15, Maryland Director 236-66-1928 1 XM 2 □ F 68 r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 ☐ Yes 2 🙀 No MD Knoxville Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with USA 21758 18926 Sandy Hook Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: 3 XWidowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Maintenance man Retail 10 of Health and Mental Hygistem 27 is marked othe other traumatic event, æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Isabelle Myers George William Ault permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 525 Brunswick Street Brunswick, MD 21716 Rick L. Ault/brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Final Journey Crematory 01/04/13 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer ^{22. Name and Address of Facility}
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ vears Colon Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Attending Physician: The law requires that the death certificate be executed eral Director. After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Vac 2 × N 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 6 To the Hospital or within 24 hours aff To the Funeral Di completely filled in Medical 1🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December 31, 2012 Mule D41667 nun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Hagerstown, MD Michael McCormick, M.D. 21742 31. Date filed (Month, Day, Year)

JAN 0 4 2013 32. Registrar's Signatur State Registrar

DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 30, 3013 1-10 PM Mariorie Virginia Alvarez)premb Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Itar Nursing OVIC G1000 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Months Hours Country) 213-34-1751 Director West Virginia Usual Residence of Decedent show at 10a. State 10b. County 10c. City, Town or Location Director or 28a-f sh notified 1 Yes 2XXNo Sparks MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 14909 Joyce Lane 21152 United States items Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. tant. If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3X Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sadie Swick Frederick Yoak 19a. Informant's Name/Relationship (Type, Print) Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 14909 Joyce Lane Sparks, Maryland Mr. Manuel E. Alvarez, Jr. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from § Sacred Ht. of Jesus Cem1/4/2013 Dundalk, Maryland 5 Other (Specify) seCharles Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 21. Signavire neral Savi Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Unidentifying Cause (Disease or iinjury (or as a consequence of) for use as the burial-transit that initiated events Due to (or as a conse resulting in death) Last auence of Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical phy attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year the a detached 1 ☐ Yes ∠y 9 ☐ Unknown Division of Vital Records, P.O. sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate | 2 **N**o 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Dea A (Check only one) examiner? 2 No 2 1 Inpatient 2 Inpatient 3 Inpa Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Mail er of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

onth. Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20a-c, 22, per fh, g935 1-4-13 sm
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav 2350 pM Marvin Alexander Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Aug 10, T957 Maryland Director 219-62-5908 55 1 X M 2 - F Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location items 23a or 28a-f sho her must be notified at 10d. Inside City Limits Director 1 √ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21218 2327 N. Charles St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural", black Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) giene. College (1-4 or 5+) Elementary/Secondary (0-12) cook food service and Mental Hygien other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Charles Alexander Joyce E.B. Grimes 19a. Informant's Name/Relationship (*Type, Print*)
Donna Alexander – daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zia Code) 6607 Aaron Meed Way; Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State cemetery, crematory or other place) 4 Donation 5 Donation 1/3/2013 in-state Bayview Crematory Baltimore, MD 2. Name and Address of Facility State Anal Hari P. Close F.S. PA 5 655 W. Baltimore St, Ba Ronal Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Interval Betweer Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events s a consequence of) burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Leta Good
Pregnant at time of death
Unknown in the past 12 months? Po Month Day Year 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsv perform 2 🗌 No Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Inpatient 2 FR/Outpatient 3 I DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkwan

East

31. Date filed (Month, Day, Year)

P006280

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ :57 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba MD voresmin Medical anti all 2002 If Under 24 Hrs. 5. Social Security Number unk If Under 1 Year 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Country) unk Director 1 M 25 F permit. Page 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health end Mental Hygiene. Importent: If item 27 is merked other then "neture", or items 23e or 28e-4 other reumetic event, the Medical English or other treumetic event, the Medical English of the California or other treumetic event, the Medical English of the California or other treumetic event, the Medical English or other treumetic event english or other 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Baltimore Nottingham 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4300 Cardwell Ave. 21236 USA 12. Was Decedent Ever in U.S.
Armed Forces? unk
1 ☐ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) hairdresser cosmetology Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print)
Stephen Ribbert – son Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8421 Harris Ave; Parkville, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date etery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 k Other (Specify) in state 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board venald S 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ate has been signed by the ettending physicien end pege 2 should be deteched for use es the burlal-transit the Hospitei or Attending Physicien: The law requires that the deeth cartificate be executed that initiated events Due to or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 D 9 Unknown Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? within 24 hours after death.

To the Funerel Director: After this certificate to completely filled in by the funerel director peg 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No |₽ 1 🙀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 28h Time of 28c. Injury at Natural 5 Pending 1 ☐ Yes 2 🙀 No NA Investigation 6 Could not be NA 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Reactitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Or. Monica Shah 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State JAN 0 4 2013 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 5:35AM Svad H Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Lanham 6019 Naval Ave. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Director 220-50-5634 1 X M 2 □ F 66 Yrs Sept. 27. 1946 Washington D.C. permit. Paga 1 and 2 should be filled within 72 hours aftar death with the Maryland Department of Health end Mantal Hygiane. Importent: If item 27 is merked other then "neturel", or items 23e or 28e-f show sny injury or other treumetic event, the Madical Examinar must be notified at 2002s. 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 No MD Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20706 United States 6019 Naval Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian. à 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 XXDivorced Completed Year or Dates. 1968-74 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Mechanic Sheet Metal 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steele Joseph Warren Bradley Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Bradley / Ex-Wife 1674 Carlyle Dr. Apt. D, Crofton, MD 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date tXX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem. 01/17/2013 Cheltenham, MD Signature of Funeral Service License 22. Name and Address of Facility Rapp runeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BLADDER Physician se or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulscase or injury that initiated events Due to (or as a consequence of): Exam To the Hoapital or Attending Physicien: The law requires that the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physicien and complately filled in by the funerel director, page 2 should be detached for use as the buriel-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 🔀 No 잍 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 3658

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State Registrar

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Hanwall

1401

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32. Registrar's Signature

412

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Bandu Emma 3:50 A December 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil Rising Sun 5 Springhouse Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 213-68-4417 1 M 2 X Maryland Sep. 19, 1954 58 permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No Maryland Cecil Rising Sun 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 **USA** 5 Springhouse Court 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lilly Rebecca Reed Harman Newton Gilespie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Springhouse Ct., Rising Sun, Maryland 21911 David E. Bandy / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Rose Hill Svcs, LLC 1-3-2013 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 essea Maira Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician END- Stage COPD Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) signed by the at id be detached f 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed To the Hospital or Attending Physician: The law required within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a Was an autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗎 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/28/12 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NS RUMPAL HUMD 2835 Smith JV Balhmore MD 21209. 5 203 31. Date filed (Month, Day, Year)

JAN 0 4 2013 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 26. Suad Cassis Bostick Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Rockville Nursing Home Rockville 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Director 577-52-7042 1 □ M 2 🛭 F 90 02/05/1922 ?7 is marked other then "naturel", or items 23e or 28e-f show treumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Adclare Road 20850 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces δ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3

Widowed 4 □ Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 I nend Mental Hygiene. 7 is marked other then "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan O'Connor - Nephew 723 Burgundy Road, Incline Village, Nevada 89451 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 Department of h Important: If Ite eny Injury or ot Date 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory: 01/03/2013 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Katri 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Hypertension disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami ettending physician end I for use es the burial-transit that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No 4 _ Pregnant at time of death ate hes been signed by the e pege 2 should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. After this certificate completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: ျု 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Hospitel or Attending 1 Natural 5 Pending To the Hospitel or Attendli within 24 hours after death. To the Funerel Director: A 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 29b. Signature and title of certifier codeep D0064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDEER SHARMA 9701 Veirs

20c. Location - City or Town, State Brentwood, Maryland Simple Tribute Funeral & Cremation Center 1040 Rockville Pike, Rockville, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 1 No 1 🗌 Yes 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 12-27-2012 Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 4 2013 Registrar DHMH 17 Rev 06-2011 **ORIGINAL**

1:00am

Montgomery

U.S.A.

Black, White, etc.

Birthplace (State or Foreign Country)

Palestine

10d. Inside City Limits

Caucasian

Own Home

1 X Yes 2 No

			Please	type or Print in E					_	e.
			For	State of Maryland				Mental Hygi		0 10726
			1 - State Registrar		Cei	tificate of E	Death	T	9	2 42736
	Physicia	ın/	Decedent's Name (First, Middle, Last,					2. Date of Death Month		3. Time of Death
Sta	Medic	al	Willy Joseph Berg 4a. Facility Name (if not institution, give s			L			13, 2012	
anger"	Examin	ier	3126 Gracefield I			Silver	Location of Death Spring		4c. County of D	
	Funeral Director		5. Social Security Number 6. Sec	3 , ,		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	- 11		067-24-4480 1 5 Usual Residence of Decedent	M 2 □ F 87	Yrs.			May 25,	1925	Germany
	/land f sho	tor	10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
	Mar. 28a-	ired	MD Montgor	nery S	ilver	Spring				1 Yes 2 No
	ith the	la La	10e. Street and Number	D1. 4 . /10		10f. Zip Code	,	1	0g. Citizen of What	Country?
	ath w	Funeral Director	3126 Gracefield	12. Was Decedent Ever in U.S.	13.1	20904 Was Decedent of Hi		ecify Yes or No-	USA 14 Page A	merican Indian,
9	er de	by F	1 Never Married 2 K Married	Armed Forces? 1 ☐ Yes 2 X No		f Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Black, W	hite, etc.
03	ırs aft ural", I Exal	ted	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🗽 No	Specify:		Specify:	white
5-("2 hot "nat edica	ple	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa kind of work done d	ation <i>luring most of worl</i>	king	16b. Kind of Busine	ss/Industry
21215-0036	lied within 72 hours after death with the Maryland I Hygiene. other than "natural", or items 23a or 28a-f sho rent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired): $\mathtt{e1}$ manage	ement		Hote	L
and	should be filed whand Mental Hyg 7 is marked othe iraumatic event,	To Be	17. Father's Name (First, Middle, Last) Willi Bergmann					ne (First, Middle, M Steiner	aiden Surname)	
Maryland	CO TO T		19a. Informant's Name/Relationship (Type Eva Bergmann – v	pe, Print) W ife		g Address (Street a			City or Town, State,	Zip Code)
altimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State ce	ace of Dispo	ver Springstion (Name of natory or other place		Date 2	20c. Location - City	or Town, State
Balti	per nit. Page 'De artment of Important: If any injury or once.		21. Signature of Funeral Service License	ade, Director	22	Name and Addres			omy Board timore, M	
			23a. Part . Enter the disease, or compleshood or heart failure. List only on							Approximate
~	Physician/ Medical	9	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseque	once of:	1100	MONO	nyorry	<i>/H</i>	3 1/63
-cold	Examiner			CORPO	VAR	Y ART	ERY	DISER	32	10 YRS
	+	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque						
	be executed sician and burlal-transit	Examiner	Cause (Disease or injury that initiated events	D						
	oe exe ician a burlal	calE	resulting in death) Last	Due to (or as a conseque	ence oi).					
68760		edic		d						
Вох	ss that the death certificate bigned by the attending physibe detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnance Other (specify)	у		23d. Date of Month	delivery Day Year
P.O.	hat the		Part II. Other significant conditions con	ntributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
	uires t n sign uld be	ed by						1 □ Ye	s 2 🗆 No 3 🗆	Probably 4 Unknown
of Vital Records,	w require s been si 2 should l	Completed						24a. Was an		autopsy findings available to completion of cause of
3ec	sician: The law sicertificate has the law lirector, page 2 s	mo;						autopsy perform 1 \sum Yes 2	ed? death	
<u></u>	ysician: s certifica director,	Be (25. Was case referred to medical examiner?				ace of Death (Chec			
₹	Physic this ce al dire	ပ္	1 Yes 2 No	lospital: 1 Inpatient 2 E			4 ☐ Nursing H	ome 5 Resider	nce 6 Other (Sp	ecify)
n of	iding P th. After t	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work' M 1 🗆	at ? Yes 2 \Bo	28d. Describe how	v injury occurred	
Division	I or Atten after deat Director:	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	(Check 2 \(\sumeq\) Medical Examin	cian: To the best of my knowle er: On the basis of examination e Practitioner: To the best of my	and/or invest	tigation, in my opľnio	n, death occurred a	at the time, date and	place, and due to the	e cause(s) and manner stated.
	하는 후 글	2	29b. Signature and title of partition	1		29c. License	number	29	d. Date signed (Mo	nth Day, Year)
	To t With To t			5		11174	4007		11112	1/7
0	To the with To the com		30. Name and address of person who as	ampleted cause of death (Itam /	23a) (Tupe =	DZ	4093		12/26	112
•			30. Name and address of person who co	empleted cause of death (Item)	23a) (Type, P	D2 EFIEU	4093 DRD	SILVER	SPRIN	GMO
	Stat		30. Name and address of person who con the part of the	ompleted cause of death (Item) 310 32. Registrar's Signatu	23a) (Type, F	DZ EFIELL	4093 DRD	SILVER	SPRIM	112 G, MD 20904

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1937 Herbert St. Baltimore 8. Date of Birth (Month, Day, May 25. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 M 2 D F Hours Director 220-64-3984 1958 Maryland Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 21216 USA 1937 Herbert St. within 72 hours after death 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) restaurant kitchen help 6 Be Department of Health and Montal High Important: If item 27 is marked oth any injury or other transpone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Frances Woods Samuel Baylor 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Figure Number, City or Jown, State, Zip Code) 1710 Candle Lane; York, PA 17404 Patricia Frazier sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Signature of Funeral Service Licenses 22. Name and Address of Facility State Anatomy Board Rona Id 655 W. Baltimore St; Baltimore, MD 21201 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions. Examiner Due to (or as a co if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a d attending physician Physician/Medical death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death Unknown Month Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by completed filled in by the funeral director, page 2 should be Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death. To the Funeral Director; After this certificate has the Hospital or Attending Physician: 25. Was case referred Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ဂ္ з 🗆 роа 1 Inpatient 2 ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Beath 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No М Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Exarpiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the bes my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 29d. Date signed Month, Day, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year , BALZANNA DEBORAH, ANN 8:36 PMM DECEMBER 7 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HARBOR HOSPITAL MEDSTAR N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7, Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 223 78 1477 1 □ M 2 🕅 F Maryland 60 08/15/1952 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or item." 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 21225 5910 Manor House Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 【 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ρ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Day Care Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Mary Ebert Marvin Simpson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21225 Samuel Balzanna / Husband 5910 Manor House Lane 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date commetency, crematory or other place)
MD State Veteran Cem. 01/03/2013 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, leceme Baltimore, Maryland 21225 nomeralle 4001 Ritchie Highway 23a. Part 1. Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician neumonia disease or condition day Medical resulting in death) Examiner 6 Months Metastatic Lung if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after deavu.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Yes 2 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year, PHYSICIAN (RESIDENT RES-001 DECEMBER, 27, 2012 DR U.N OZUMBA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. HANOVER MD 21225 BALTIMORE,

Registrar

DHMH 17 Rev 06-2011

State

32. Registrar's S

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	Funer	al			Age (In yrs. la		If Unc	ler 1 Year	If Under 24		B. Date of Bir	th		9. Birth	place (State or Fore	eign
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# 5	Hospitel or Attending Physicien: The law requires that the deeth certificate be 24 hours after death. Funerel Director: After this certificate hes been signed by the ettending physic stell filed in by the funeral director, page 2 should be detached for use as the b			8							City or Tow					
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2	Medical	(Check 2 \(\text{Medical Exart}\)	nysician: To the best miner: On the basis ourse Practitioner: To	of examination	and/or inves	tigation, i	n mv opinio	 death occur 	red at the	e time date a	ind plac	e and due to	the car	ise(s) and manner st	tated.
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			30. Name and address of person who	completed cause of	death/(Item	23a) (Type, F	Print)	ontro	Chan	100	Ct- P	PN	500	TIN	11502120	7
		ate	31. Date filed (Month, Day, Year)		strar's Signat	ure	, , , ,	1 10/	UNIVON I	راست	<u>۷-۱۷</u>	1 70		100	-0301111011	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ames Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washin Drince 71 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace **Funeral** 1**X** M 2 □ F Days Hours Min. December 23" 1941 Jackschville, Fla. **Director** 256-66-0050 Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Funeral Director 1X Yes 2 □ No D. C. Washington 10e. Street and Number 2006 Savannah Place, S.E. 20020 Inited States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 Yes X No Specify: 3 Widowed 4X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Vehicle Driver Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Market 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jessie R. Perry ပ James O. Benson, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 3289 Medina Dr. Jonesboro, Georgia 30236 James O. Benson, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glenwood Cemetery 01/05/13 Washington, D.C. 4 Donation 5 Other (Specify) Signature of Funeral Ser 22. Name and Address of Facility **Pornette & Associates Funeral Home, inc.** CC0418 28th Street, N.E. Washington, D.C. 20018 Art 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physicians, u/se/e disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to lor as a conse juence of the burial-trans Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) Yes 2 No the i 9 Unknown ed by i signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1-Natural 5 Pending injury work? 2 🗆 No Accident Investigation after deat Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wingston Rd Tames MD Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 Registrar

✓ DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene 2 U 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 28, 2012 George Charles Conklin 5:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Rock Spring Village Forest Hill Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) Director 151-18-2592 1 □XM 2 □ F Yrs. June 17, 1926 86 New Jersey 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director of Mental Hygiene.
In Merked other then "rature!", or kems 23a or 28e-f simmerked other then "rature!" or kems 23a or 28e-f simmeric event, the Medical Examiner must be notified. 1 🗆 Yes 2 🗖 No Bel Air Maryland | Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 636 Lochern Terrace 21015 USA filed within 72 hours eftar death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1★ Yes 2 No
If Yes, Give Black. White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Person Retail B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ᅆ 90 Dewitt (nuk) Conklin Rachel (unk) Neill . Pege 1 end 2 should b ment of Heelth end Mer tant: If Item 27 Is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 636 Lochern Terr., Leslie Conklin / Daughter Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Rose Hill Svcs, LLC ò 1 ☐ Burjal 2 🖟 Cremation 3 🗆 Re parmit, Pege Depertment of Important: If eny Injury or once, 1-3-2013 Bel Air, Maryland 4 Donation 5 DOnter (Specifi 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) hronz Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or se a consequence or) for use as the burlal-transit or Attending Physicien: The lew requires thet the deeth certificate be executed Due to (or as a consequence of): Pue that initiated events resulting in death) Last ettending physicien Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year signed by the el 9 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, s been significant 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has rai director, page 2 autopsy 1 ☐ Yes 2 🔯 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ KNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Assisted After this funaral o 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Living 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No efter death Director: A Investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) hin 24 hours eft the Funerel Di mplately filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier To the F within 2. 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VI chre m 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

12-09790 Yvonne Coffee Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 42742

		1- For State Registrar			Ce	ertificate of	Death	7			1	Reg. No.					
Physici		1. Decedent's Nam	e (First, Midd	lle,Last)						2.	Date of De		V	\Box	3. Time of Death		
dical Exami	ner	Yvonne	Coff	00						ļ	Month Decembe	Day er 23, 2	Year 2012		1826 hrs		
		4a. Facility Name (number)		4b. City, To	own, or Lo	ocation of	Death		40	. County of	f Death			
		Prince Geo	rge's Hos	oital			Cheve	erly				F	Prince George's				
Euroral		5. Social Security	Number	6. Sex	7 Age (In vrs	last birthday)	If Unde	r 1 Year	If Under	24Hrs.	8. Date of B	irth (MM/	(DD/YYYY)	9. Birtl	hplace (State or		
Funeral Director		200					Months		Hours	Min.		,	1	Foreign	New York		
Director		266-04-	9937	1 M 2X	F	63 Yrs					Aug.	. 13, 1949 Country) Total					
.		Usual Residence o			140- 03	T		_							10d. Inside City Limits		
w any		10a. State	10b. County		Toc. Cit	y, Town or Locat	ion										
and sho	ō	MD	Prince	e George	's La	ndover									1 X Yes 2 No		
Maryland 28a-f show d at once.	Director	10e. Street and Nu	ımber				10f. Zip	Code				10g. Citi	zen of Wha	at Coun	try?		
the N	급	1611 Co.	lumbia	Avenue			2078	85				USA					
WD Prince George's Landover 106. Street and Number 106. Street and Number 106. Street and Number 107. Zip Code 107. Zip Code 107. Zip Code 108. Street and Number 109. Zip Code 110. Zip Code 120. Zip Code 111. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1														an Indian, Black,			
item item	MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Disposition 10g. Citizen of Non 11d. Race- 11d.										etc.						
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irs af											iness/Ir	idustry					
2 hou	15. Decedent's Education (Specify only highest grade completed) 16a																
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with with	E	17. Father's Name		Last)		Radze	1065				irst, Middle,						
1, 18 H. J. B. T.				, ===,						•			,				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Fred Pompey Julita Ramos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town											ity or Town	State	Zin Code)			
shou and 17 is r	٢	Michael Arnett/Husband 1611 Columbia Avenue, Landover, MD															
MD and 2 she ealth and con 27 is		20a. Method of Dis		c/ nusban		. Place of Dispos					Date				Town, State		
of Herit		1 Burial 2		n 3 Remov		crematory or ot			,					1			
Pag nent		4 Donation 5			На	rmony Me	m. C	emete	ery	1/4/	2013	Ну	attsv	7 i 11	e, Maryland		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		21 Signature of Fu	ineral Service	Licensee /	1 . 0 /	22. N									Home, Inc.		
E.E.C.s CO		Shur	man	Wa Y	MAN										D 20785		
Physician		23a. Part I. Enter the			at caused the deat	h. Do not enter t	ne mode o	f dying, su	ich as car	diac or re	espiratory a	rest, sho	ock, or hear	t	Approximate Interval Between Onset and		
/Medical		Immediate Cause (-	I been a minute	nsive Cardiova	ascular Disea	ise								Death		
Ēxaminer		or condition resulti			is a consequence	of):					•						
		Sequentially list co	onditions.	b													
	ner	if any, leading to in cause. Enter Under	nmediate		is a consequence	of):											
	Examiner	(Disease or injury t	that initiated	С.	is a consequence	of):					-						
nsi ed	EX	events resulting in	nts resulting in death) Last Due to (or as a consequence or): d.														
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Sa	UNPENDED)	AMEND	:D												
O, e be e ysicia buria	Physician/Medical		·									Loo	Data of a	de livro e v			
3760, ficate be g physici s the buri	Z	IF FEMALE: 23b. Was decedent			es, outcome of pre ve birth		tal death	3	Ectopic p	regnanc	v	230	d. Date of o		ay Year		
certi	cia	past 12 months	s?		egnant at time of c	le oth	her (Speci] =	g	,				7		
Box 687 ne death certific the attending part of for use as the	ysi	1 Yes 2 🗸	No 9 🗌 Un	known 9 U	known	٠ ا_ ١ ٥،	ici (apas	,,									
t the		Part II. Other signi	ificant condi	tions contribution	g to death but not	resulting in the u	nderlying	cause giv	en in Part	1.	23e. Did	tobacco	use contrib	ute to th	he cause of death?		
tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detacl	ā										1 Y	s 2	No 3	Proba	ably 4 🗹 Unknown		
of Vital Records, ag Physician: The law require After this certificate has been si meral director, page 2 should b	Completed										24a. Was	an			opsy findings available		
aw nas b	ğ									_	auto	psy orm <u>ed</u> ?		nor to co eath?	empletion of cause of		
Rec The l	ĕ										1 🗸 Yes			✓ Yes	2 No		
al minimum.	Be	25. Was case refer examiner?	red to medica				2	6.Place of		heck on	y one)						
Z ig Signal	.0	(mm)	2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 D0	OA O	ther ₄	Nursing H	Home 5	Reside	nce 6	Other:			
n of Vit ding Physic After this funeral dire		27. Manner of Deat	th	28a. D	ate of Injury onth, Day,Year)	28b. Time of I	njury 2	8c. Înjury	at Work?	28	d. Describe	how inju	ury occurre	d	-		
on endin	ij	1 V Natural		ding	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 Ye	s 2 N	40							
Division tal or Attendia rs after death. al Director: A led in by the fu	Ę	2 Accident 3 Suicide	[]	estigation 28e. I	Place of Injury - At	home, farm, stree	et, factory,	office buil	lding, etc.	28			nd Number	or Run	al Route Number, City		
ital o	1																
Tosp 4 hou func ely fi	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only)											as state	d.				
the I	The standard of the standard o										cause(s)						
To With	Me	29b. Signature and	title of certifi		er stated.		29c.	License r	number			29d.	Date signe	d (Mon	th, Day, Year)		
		/ //	1.0	IND				O.C.M	.E.			Dec	ember 2	24, 20	12		
_		1 year	Cour		aven of death (i)	02-V											
2		30. Name and addr Laron Lock			cause of death (Ite ical Examiner		ltimore	Street	Baltimo	ore Mr	21223						
البيه					Registrar's Signa			J., 001,	- annin	, 1416							
St	ate	31. Date filed (Mon		4 2013 3	A agent a	A MA	Med										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DeMenth 219 y 2012 6:15 A_M Donna Rae Catherman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Nursing Center Towson If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JUPY" 124, 1944 Davs Hours Min. 214-44-1146 Vframia Director 68 1 0 M 2 X F Yrs or 28a-f ahov parmit. Paga 1 end 2 should ba filed within 72 hours aftar daeth with the Maryland Department of Health and Marital Hyglana. Important: If Item 27 is merked other than "natural", or Items 23e or 28a-f ahor any injury or other traumetic event, the Modical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Dunda 1 k Mary land Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Unites States of America 21224 930 Dalton Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Year or Dates Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Frederick Lynch Ruth Eleanor Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Leroy Catherman Husband 930 dalton Ave Dundalk, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. Dec 31, 2012 Towson, Maryland Signature of Funeral Service Ligensee Neiser 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Michael 7922 Wise Avenue Dundalk, Maryland 21222 wha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law raquiras that the death cartificate be axacuted that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day ant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has baen sirrel diractor, paga 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 🗆 No tor: Aftar this certific tha funerel diractor, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s eftar daath. I Director: Aft id in by tha fur 1 Tes 2 No Investigation 3 Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours efter To the Funeral Direc complately filled in by Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D007128 Name and address of person who completed cause of death (Item 23a) (Type, Print) #4105, Baltimore, MD 21204 Shaheey

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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67011

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

ပ္

State Registrar

31. Date filed (Month, Day, Year)
JAN 0 4 2013

29b. Signature and title of certifier

PAVAN

CHERWU, M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

				ase Type or					All Copies Mental Hyg		gible.				
		•	For State Registrar	Olulo 0	, ivial ylai		rtificate of			Reg. No.2	112	42745			
	Physicia	n/	Decedent's Name (First, Middle						th	Vear	3. Time of Death				
	Medic	al_	4. E. 39. N	Betty C			T			ber 27, 2012 1:00 p					
	Examin	er	4a. Facility Name (if not institution Sunset Ridge				4b. City, Town,	Frederic	4c. County of Death Frederick						
There's	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year Months Days	r If Under 24 Hr	8. Date of Birtl		Birthplace (State or Foreign				
	Director		579-09-0719 Usual Residence of Decedent	1 □ M 2 🗖 F	92	Yrs.	Wiching Bay	710010	02/28	,	000	Country)			
	show	tor	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits			
	28a-	Director	Maryland F	rederick			Ties was a	Freder				1 K Yes 2 □ No			
	with th	7021 Rock Creek Drive 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.)										S.A.			
	death v														
36	within 72 hours efter death with the Maryland glene grethen "natural" or items 23a or 28a-f sho the Medical Examinar must be notified at											white			
9	hours nature lical E	lete	15. Decede	nt's Education	tes.	16a. Dece	dent's Usual Occ	upation	1	16b. Kind of E	Business/Ir				
2	hin 72 ne. then "	Completed	Elementary/Secondary (0-12)	est grade completed) College (1-	4 or 5+)		OO NOT use retire	· .	orking		Own	r Home			
d D	i filed wit tal Hygie d other event, tr	Bec	1 2 17. Father's Name (First, Middle,	Last)		<u> </u>	по	nemaker 18. Mother's N	ame (First, Middle, i	Maiden Surnan		i nome			
/lan	d be fil Mental arked artic ev	욘		Jacob Cohe	n.					ncis Ma		66			
Man.	2 should lith and Me 27 is marl traumati	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 8823 Adventure Avenue, Frederick, Mary													
ē,	and 2 Health tem 27 other tr		Susan Haynes 20a. Method of Disposition	- vaugnie	20b.	Place of Disp	osition (Name of	:	Date		Oc. Location - City or Town, State				
Ē	Page 1 nent of I ant: If it ary or o		1 🕅 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State Kin	cemetery, cre g Davi	matory or other p d Mem. C	ace) Grdns 12/	30/2012		-	ch, Virginia			
Baltimore, Maryland 21215-0036	permit. Departr Imports any inju														
	TO = 60	2.3	23a. Part 1. Enter the disease	110000000	./						Spru	Approximate			
_ F	Tiysician/	2 2	shock, or heart failure. List Immediate Cause (Final	only one cause on eac	ch line. ^							Interval Between Onset and Death Dau			
	, Medical Examiner		disease or condition resulting in death) a. Respiratory Dysfunction Secondary to Cardiovascular Disease Due to (or as a consequence of):												
		Sequentially list conditions, if any, leading to immediate b. Electrolyte Imbalance Due to (or as a consequence of):										1 Day			
	executed n end ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. Atrial Fibrillation												
			resulting in death) Last	Due to (or as a conseq	uence of):]			
90	cete b physic s the b	edic		d											
Division of Vital Records, P.O. Box 68760	requires that the deeth certificete be executed been signed by the attending physician end should be deteched for use es the burial-transit	Physician/Medical	IF FEMALE; 23b. Was decedent pregnant	23c. If yes, outo	come of pregna	ancy aldeath 3	☐ Ectopic pregna	ncv		23d. D	ate of deliv	very			
8 B	e deeth the att hed fo	yslci	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		nant at time of		Other (specify)	,		M	lonth	Day Year			
Ö.	that the led by detec	y Ph	Part II. Other significant conditi	ons contributing to de	eath but not re	sulting in the	underlying cause	given in Part I.	23e. Did to	bacco use con	ntribute to t	the cause of death?			
ds,	quires en sign	pet p	Hypertension	, Diabetes	Melli	tus, D	ementia,		1 🗆 `	∕es 2 □ No	3 🗆 Pro	obably 4 Unknown			
So	law re has be e 2 sho	Completed by	Bellous Pemp	higold wit	th Chro	nic Im	muno-sup	pression	24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of			
E	n: The ficate or, peg		25. Was case referred to medical				26	Place of Death (Ch	1 🗆 Yes	med? 202 No	death?	2 □ No			
iga Ka	lysicie Is cert direct	To Be	examiner? 1 ☐ Yes 2	Hospital:	Inpatient 2	ER/Outpatie	0			ence 🔂 Otl	her (Specif	y Asst Livin			
יסר	al or Attending Physics: a after death. I Director: After this could be be to be the funeral director.		27. Manner of Death 1∰Natural 5 ☐ Pendi	9	of injury h, Day, Year)	28b. Time o injury	w	ury at ork?	28d. Describe h						
Sior	Attend r death octor: / by the	Certificate:	2 Accident Invest 3 Suicide 6 Could 4 Homicide detern	ained 28e. Place			M 1 reet, factory, offic	Yes 2 No	28f. Location (S	treet and Numi	ber or Rura	al Route Number,			
<u>≥</u>	Ital or urs afte al Dire		4 D Homode Getern	buildir	ng, etc. (Specif	y)			City or Tow	n, State)					
	To the Hospital or Attending Physicien: The law requires that the deeth certificete be within E4 hours after death. Within E4 hours after death. To the Lameral Directors After this certificate has been signed by the attending physicis completely filled in by the funeral director, pege 2 should be deteched for use es the bu	Medical	(Check 2 Medical		is of examination	n and/or inve	stigation, in my opi	nion, death occurre	d at the time, date a	nd place, and d	ue to the ca	ause(s) and manner stated.			
1	To the within To the compl	Σ.	only one) 3 ertifyin 29b. Signature and title of of title	Nurse Practitioner:	1/1/	my knowledge		nse number		2 9 d. Date sign					
	200		+ They	MC	WH		R	05064	0	12-0	27-1.	2			
	1 gm		· Tanela.	who completed caus L. Eat	e of death (Iter	n 23a) (Type,	Print) 420=	2 Green	Valley	Rd n	20n (0vic MD 2177			
	Stat Registra		31. Dáte filed (Month, Day, Year) JAN 0 4 2	013 Serve	egistrar's Signa	far	w	U				2177			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5,17, per fh, g935 1-4-13 sm State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 945 PM **Physician** conard timan 20% cember /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number **3747** 6. Sex If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ¥Yes 2 No Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) MONICO. Funeral Was Decedent Ever in U.S. Armed Forces? er than "natural", or items the Medical Examiner mu 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 No 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: N/Fe 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 17. Father's Name (First, Middle, Last)

Emory Emerson Coffman 18. Mother's Name (First, Middle, Maiden Surrame) other traumatic event, ith and Mental h Be မ Ethe T, NNel. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ffman DERNALD MD 2, 1221 Marlyn 1014 0 20b. Place of Disposition (Name of gemetery, crematory or other place)

Myview Crematory 20a. Method of Disposition Date 20c. Location - City of Town, State 1 ☐ Burial 25 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If it any Injury or o Dalhmore 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNE/a/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** De to (3s consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause Elter U. Janying Cause (Disease or injury that initiated events Due to (or as a consequence of) nding physician and use as the burial-transit Exami The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760. attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, page 2 should be Diabete 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed' 2 🗌 No 1 🗌 Yes 2 X No 1 🗌 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient Other: 4 \(\hat{\cap}\) Nursing Home 3 🗌 D0A 1 ☐ Yes 2 X No 2 ER/Outpatient 5 Residence 6 Other (Specify) Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No hours after death. Ineral Director; A filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1487953865 December 30,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alexand 21 4940 Eastern Avenue, Baltimore, MD, 21224 Keuin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 park 4 Registrar

DHMH 17 Rev 1/2001 11595

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	le Hosp n 24 ho le Fune bletely 1	Medical	(Check 2	☐ Medical Ex	Physician: To the caminer: On the b Nurse Practition	asis of e	xamination	and/or invest	tigation, in	my opinic	n, death occ	curred at	the time, date	and place	e, and du	e to the ca	ause(s) and manner stated.		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0:15AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Genesis - Randallstown If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 une 15, Min Days Hours Alabama Director 1x□ M 2 □ F 216-36-1690 73 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. attribute if item 27.5 is marked other then "nature!", or items 23e or 28a-f shoury or other traumatic event, it.— Medical Examiner must be notified at oury or other traumatic event, it.— Medical Examiner must be notified at Director 1 √ Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21202 10 N. Calvert St; Apt 542 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 L Never Married 2 Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 🖾 No Specify. Specify. 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) transportation truck driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Mary Ware James Carson Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44 Lynwood Dr; York, PA 17402 Neta Walker - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott Date 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 \boxtimes Other (Specify) in state Signature of Funeral Sarve License 22. Name and Address of Facility State Anatomy Board Director 655 W. Baaltimore St; Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Ath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami attending physicien and I for use as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Vursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural Certificate: 28d. Describe how injury occurred 5 Pending Investigation ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
PAMELA M. ALINCS

2. Registrar's Signature

JAN 0 4 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 23, 2012 12:42 PM Lynn Diane Carr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Days Director 215-42-8970 69 1 □ M 2 🛣 F Maryland I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 X No Pvlesville MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21132 USA 1730 Eden Mills Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 全 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 teacher education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of be Harry Thomas Cline Laverne Rachel Fleming permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8362 Academy Rd; Ellicott City, MD 21043 Courtney Bond - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Si Director 655 W. Baltimore St; Baltimore, MD 21201 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury Examine Due to (or as a consequence of): use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death Year be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 2 No After this certificate 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (A) Other (Specify) 1 ☐ Yes 2 ☑ No မ HOS pier 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 5 Pending 1/ Natural 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier as MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chreet Suili 4105 Ballimore MD 21204

Registrar DHMH 17 Rev 06-2011

State

SYED Q. ABBAS MD

JAN 0

31. Date filed (Month, Day, Year)

6701

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Patricia Month Claytor 7150 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Centar If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 216 36 9334 Director 1 □ M 2 🗓 F Maryland 12/16/1938 permit. Paga 1 and 2 sh uld be filed within 72 hours after death with the Maryland Department of Health an Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 40 Birch Avenue 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black White etc. δ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th Bus Driver School Bus æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Ervin Rosskopf Helen Ruth Rosebery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felton Claytor Sr. / Husband 40 Birch Avenue Glen Burnie, Maryland 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/03/2013 Cedar Hill Cemetery Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ END STAGE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law raquires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day 4 Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 ☐ Yes 2 ANo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 25No 2 🗌 No 1 Tes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XN0 မှ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 36581 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 445 DeFe

State Registrar

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	2121 within 7; giene. ler than		Elementary/Secondary (0-12)	College (1-4	4 or 5+)	Engi		reureay				c	<u>ivil</u>	Ser	vice	
3	fand be filed lental Hy rked oth iic event	To Be	17. Father's Name (First, Middle, L	·					_		e (First, Middle	•	n Surname)		
	Maryland 2 should be filed th and Mental H 27 is marked otl traumatic even		Nicola (nmn) I			10b Maili	na Addrasi	(Street :			(nmn) I		or Town S	tata Zir	Codel	
_	T W -		Mattie R. DiCar		se	1	_				l Air.	-			•	
3			20a. Method of Disposition 1 Durial 2 Cremation		20b. P	lace of Dispo emetery, crea	sition (Nar	ne of			Date				Town, State	
73	Baltimo permit. Page Department of Important: If any Injury or	ما	4 Donation 5 Other (S	1	Har	ford I									Maryland	
O	Balti permit. Departr Importa any Inji	eg	Ments ag	my L							Comas I d, Abii				and 21009	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that can	aused the death								•		Approximate Interval Between	
	Priysicia Medic		Immediate Cause (Final disease or condition resulting in death)	_ a A	or is a consequ	226	n	n	eur	w	ria				Onset and Death	
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4	_ =	iner in	Sequentially list conditions, in any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Sue to (b.	r as a cursequ				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1						
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11	O be ex sician e burla	<u>6</u>		d		,										
2	Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate buthin 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b	Completed by Physician/Medic	IF FEMALE:													
\cup	Box 6 death ce	cian/	23b. Was decedent pregnant in the past 12 months?		ome of pregnar Birth 2 D Fetal ant at time of d	Ideath 3	Ectopic		;y				23d. Dat Mor		ivery Day Year	
	O. B tt the de I by the etached	hysi	1 Yes 2 No 9 Unknown	9 🗆 Unkno												
	s that the igned by the detach	ğ	Part II. Other significant conditio	ns contributing to de	ath but not resu	ulting in the i	underlying	ause giv	en in Part	l.					the cause of death?	
6	rds requir been s	etec	-				·				24a. Was				obably 4 Unknown	
3	Vital Records, ysician: The law require is certificate has been si director, page 2 should	l g									auto perf	opsy ormed?	p	rior to death?	completion of cause of	
7	tal F cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	11				26. Pla	ace of Dea	ath (Check	1 🗆 Yes only one)	2 (38)	40	res	213-110	
	of Vil ig Physic ter this conneral dire	<u>اء</u>	1 Yes 2 No	Hospital: 1 XIII 28a. Date o	npatient 2 🗆	ER/Outpatie			4 LJ N		me 5 Res				fy)	
7	ision of Vital Records, Attending Physician: The law requires r death. ector: After this certificate has been sign by the funeral director, page 2 should be	icate	1 Pending 2 Accident Investig	g (Month	n, Day, Year)	injury	M	8c. Injury work 1 🏻	/aι ? Yes 2.⊑	- 1	28d. Describe	how inju	iry occurre	d		
	Division al or Attendii s after death. al Director: After ed in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	nod 28e. Place o	of Injury - At hor g, etc. (Specify)	me, farm, str	eet, factor	, office		- :	28f. Location (City or To			r or Rui	al Route Number,	
	Spital cours at course at cours at course at cour	cal	29a. Certifier 1 Certifying	Physician: To the be	est of my knowle	edge death	occurred a	the time	date and	I place ar	nd due to the o	auea(e)	and mann	ar se et	eted	
W	the Hos thin 24 h the Fur mpletely	Medical	(Check 2 Medical E	xaminer: On the basis Nurse Practitioner:	s of examination	and/or inves	tigation, in	ny opinio	n, death o	ccurred at	the time, date	and plac	e, and due	to the o	ause(s) and manner stated	
8	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo) 12/20/20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Monriec 16 Absence on Place Absence 2100										(Month	, Day, Year)				
17			30. Name and address of person w	vho completed cause	of death (Item	23a) (Tvna 1	Print)	20	1-18	0 7		. 2	7-41	~ 16		
33	12+1		Andrew,	Mnowiec	16 0	Jeen	Lean	PL	ove	A	werke	eu	210	01		
8	S Regis	tate trar	31. Date filed (Month, Day, Year) JAN 0 4 2013	General 32. Re	gistrate Signat	all										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#10c.perFH, G935, 1/4/2013, WS
State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month CHAPLES :37am DIGGS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death n, UNINELENTER Mayland Baltone USA Medical Ce MP If Under 1 Year | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth 217-34-1991 (Month, Day, Year) Director 1**X** M 2 □ F Yrs 76 MD. MAY 28, 1936 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Items 23e or 28e-f show eny Injury or other treumatic event, the Medical Examinar must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director AICKERSON Gaithersburg MO. MONTGOMERY 1-Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Me CAUSLAND PL. 20877 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business/Industry
FLEET PRIDE TRUCK 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) +TRAILER PARTS DRIVER TRUCK 12 17+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM DIGGS DOROTHY ROLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LISA SMITH 16908 WALDEN AVE CLEVELAND OHIO 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Importent: If It eny Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State JAN. 5, 2013 FREDERICK FAIRVIEW CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FUNERAL I from E Rollers Q. Sount ST FREDERICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): hem Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit lor Attending Physiclen: The law requires thet the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an perform 25. Was case referred to medical examine?

1 Yes 2 No Be (**Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending
Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the l within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) neM D007-3009 12/201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SONTH GREENEST, BALT. MD. 2120 SHAHAB TOURSAVADKOH 31. Date filed (Month, Day, Year)
JAN 0 4 2013 32. Registra 's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Michael, Wayne Davis Dec 17:23 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore VA Balkmore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days Funeral 6 Sex If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 217.54. Hours (Month, Qay, Year) Director 1 XM 2 - F 28a-f shov 1 and 2 should be filed within 72 hour after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shorther traumatt event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No GWYNN 1 Jak 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Street 21207 USA Alter 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Service Mail Carrier Be 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ford Davis Edna Comora Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 117 N. Alter Street Guynn Dak MD 21207 stephanie ravis Awit 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Puneral Services 8 Liberty Road Pandalbtown MD 2193 23a. Part 1. Ent if the usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h. art frillure. List only one cause on each line. Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 2 days C. diff infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 1 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Day 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy performed? Yes 2 No of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending Division Work / 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 740579473 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 North Street Bathmore MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 12 Day 19 1:25 Physician/ P Rosa Mae Doyle Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince Georges 4b. City, Town, or Location of Death **Examiner** Sacred Heart Hyattsville If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 255-42-0844 Days Hours (Month, Day, Yea. 5/15/1927 1 - M 2 XF Director **Georgia** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges MD ortant; If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified Hyattsville Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 20782 10e. Street and Number 5805 Queens Chapal Rd Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

ACCUPATION. 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene.
7 is marked other than "r Government. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Menta. Important; If item 27 is marked any injury or one. Nancy Houston Sylvester Langley 19a. Informant's Name/Relationship (Type, Print)

Joy Williams- Doyle Grandbaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Randbligh Street NW Washington DC 20011 20a. Method of Disposition
1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Washington National Suitland 12/31/2012 , Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Sarvice licensee 20011 22. Name and Address of Facility Hame 716 Kennedy St. NW Washington DC Johnson & Jenkins Funeral 23a. Part 1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🗷 No detached P.O. by 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an nas autopsy 2 🗆 No 1 Yes 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be Other: 1 Yes ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier DO 51122 of person who completed cause of death (Item 23a) (Type, Print) VARNUM 87

DHMH 17 Rev 7/2009

Registrar

IANO 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #6 per fth 2938 4-8-13 sm | State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Year 2012 Physician/ 3Day Virginia Dublin 5:05 D M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Hebrew Home of Greater Washington Rockville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday **Funeral** (Month, Day, Year) 3-9-1918 Pennsylvania 091-10-7679 94 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director MD Montgomery Rockville 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 6121 Montrose Road 20852 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No Specify: If Yes Give Completed 3 X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Esther Altzman Harry Labell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4712 Jefferson Street, Hyattsville, Maryland 20781 Ellen Levy - Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 1-4-2013 Maspeth, New York Mt. Zion Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Lieensee Edward Sage1 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to lor as a consequence of if any, leading to immedicause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 month signed by the atter Day Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 2 1 No 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at w<u>or</u>k? 28d. Describe how injury occurred Natural 5 Pending 2 1 No 1 Yes Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ZOOVIA AMAN, MD 31. Date filed (Month, Day, Year, 32. Registrar's Signature State

Registrar

12-09857 Rudolph Driver Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Projection Projection Proj	Rudolph Driver	4	State of Maryland / Department of Health and Mental Hygiene -For State Certificate of Death Reg. No. 2012 4275
The control of the co	Physicia		Registrar 1. Decement's Name (First, Middle-Last) 2. Date of Death 3. Time of Death
2304 Winchester Street: Apt. O Bellimore Button: Button: Vivo Click State Doard fingedMonory S. Ritigiano (State of Congress) S. Ritigiano (State	_	ıer	Kudolph Driver December 25, 2012 Year 2306 hrs
The control of the			Ha. Facility Name (ii not institution), give street and number)
Commonwealth Comm			Foreign
To Street and Number Street Street Street Street Street Street Street Street Street Street Street Street St	Director	_	216-62-6749 1XM 2 F 5 Yrs. 11111 1953 Country) / 1
The control of the	any	ŀ	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
The control of Depositive Services and the control of Serv	land f show	ğ	MID CALIFITYOU F
Secretary Secr	ne Mary	Sirec	toe, sileet and running
19th Malini Agreement Name/Reflexingcoping (Type, Print) 19th Malini Agreement (Symp and Name) of Deposition (Name of demony) 19th Malini Agreement (Symp and Name) of Deposition (Name of demony) 19th Malini Agreement (Symp and Name) 19t	n with the ms 23a be not		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-
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Continued Cont	Ore, ges 1 an of Hea if iter		1 Burial 2 Cremation 3 Removal from State Crematory or other places
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296. Signature and attries of certifier O.C.M.E. December 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar' Signature	rand ransi		22- 27- 20- 5
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296. Signature and attries of certifier O.C.M.E. December 26, 2012 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar' Signature	ie Hospi n 24 hour ie Fuoer letely fill		29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month, Day, Year) 32. Registrar Signature	To th within To th comp	Medi	and manner stated.
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Poolster IANO 4 2013 (Buckey).			

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ 9:15 DICKERSON 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Washington Anne Arundel Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) 6. Sex **Funeral** (Month, Day, Year) 213-20-2758 87 **Director** 1 M 2 F Sept. 23, 1925 Maryland or 28a-f shov 10c. City, Town or Location 10d, Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No Millersville MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Funeral 239 USA 21108 609 Waterwheel Ln., Apt. 12 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🖾 No Black, White, etc. 1 Never Married 2 Married ō ð 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: "natural", White Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teller Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maryland permit. Page 1 and 2 should be filed Department of Health end Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 20129. ဥ Hollowell Cora Scharnetzi Gustav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 790 Stevenson Rd., Severn, MD 21144 Donna J. Catterton (Daughter) Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Loudon Park Cemetery 1 X Burial 2 Cremation 3 Removal from State 1/4/13 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ardiac disease or condition resulting in death) Medical Examiner minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine 5 years ettending physician end for use as the burial-trensit or Attending Physician: The law requires that the death certificete be executed Corman that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has comadin 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No **Division of Vital** filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 ☐ Yes 2. ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier 1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D007305

DHMH 17 Rev 06-2011

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KNSten M Perchert

2. Registrar's Signature

XVISTON M 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 5,55 PM FRANKLIN WALTER 31 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7206 LEONA . Social Security Number PRINCE STREET for estville GEORGE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/02/1925 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Months Hours Country) D.C 1 ₹M 2 □ F Director 218-20-2468 87 Usual Residence of Deceden r than "natural", or iteme 23a or 28a-f shov the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7206 Leona Street 20747 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tile Layer Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jack Darne Fannie Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Deavers / Sister 7206 Leona Street, Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗋 Burial 2 🜠 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) 1/3/2013 Chesapeake Crematory Beltsville, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Jarole 4 harshall Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Qnset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 JE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Day Year 1 ☐ Yes → 1 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 100 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 🐼 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Yertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certificing Nurse Prantitionar T. the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1752 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9500 ANNAPOLLS RUAL Act LANHAM

Registrar
DHMH 17 Rev 06-2011

State

32. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 🗆 M 2 🔼 F 28a-f show 10c. City, Town or Location 10d. Inside Çity Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Model Examiner must be notified at any injury or other traumatic event, the Model Examiner must be notified at annea. Completed by Funeral Director 1 MYes 2 ☐ No 10e Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 40Me Ma DUIN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee - ASNON FUNERA dalada 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Non disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as: IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai
completely filled in by the fu Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number -00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Donoho Melvin Charles 2012 2:50 A December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Dundalk 2045 Jasmine Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Funeral Days Hours (Month, Day, Year) 1 XM 2 🗆 F Director 10 er then "neturel", or Items 23e or 28a-f show the Medical Examiner it ust be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours efter death with the Maryland **Funeral Director** 1 X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 12. Was Depedent Ever in U.S. Armed Forces?

1 Wes 2 No If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 📈 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: 3 Widowed 4 Divorced Completed Year or Dates. Korca 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Page 1 and 2 should be filed within 72 ment of Health end Mental Hygiene. ent: If Item 27 is merked other then ury or other traumetic event, the Ms Elementary/Secondary (0-12) College (1-4 or 5+) lekem 10 Be 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21222 20b. Place of Disposition (Name of cemetery, crematgry or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a
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importent: If ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Se 21222 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cash line. Immediate Cause (Final Physician/ 463 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying as a consequence of Examine To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours effer death.

To the Funerei Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) To Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License numb

30. Name and address of person who c impleted cause of death (Item 23a) (Type, Print)

TOLAGIRO

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Brittany Month 12 Year 4:25 PM Dean Medical 2013 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maryland Medical Center Iniversity of Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours June 23, Country) Maryland Director 220-34-4735 1 M 2 F 23 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 553 Half Mile Court 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: black Completed 3 Widowed 4 Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry grade completed) (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Harold Peters Avis Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avis Dean - mother 553 Half Mile Court; Baltimore, MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state Signatur Funeral Sonice Licenses Sonace 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Respiratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Right failure heart that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? After this certificate ☐ Yes 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, it 25. Was case referred to medical examiner?
1 ☐ Yes 2 → No B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1. Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Cappelletti

31. Date filed (Month, Day, Year)

1255607354

225. Greene St. Baltimore, MD

29d. Date signed (Month, Day, Year)

12/30/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10: 45 P M Day 3/ Year Month Physician/ DECEMBER 2012 Eve Mae Foreman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CITESAPEAKE HOSPITAZ BEZ ATR HARFORD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6 Sex **Funeral** (Month, Day, Year) Hours **Director** 215-12-2505 1 □ M 2 🕱 F 88 26, 1924 West Virginia Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h County 10c. City. Town or Location 10a. State Director 1 Yes 2 XNo Forest Hill Harford Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21050 1209 Sharon Acres Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian "natural", or item edical Examiner n Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 XWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Store Cashier permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other thany injury or other traumatic event, the once. 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sarah Ann Thompson မ Thomas Alvis Chedister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 916 Lakeside Terrace, Bel Air, Maryland 21014 Dawn Foreman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remote 4 ☐ Conation 5 ☐ Other (Specify) val from State Parkville, Maryland 1/3/2013 Moreland Memorial Pk. 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23al Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY PAILURE CHRONIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine and the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death asn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 No 25. Was case referred to medical Vital To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No of 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending Division s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) n. 24 hours *•• Funeral Dire *• filled in bv þ determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗌 29b. Signature and title of certifier 29c. License number ARRONDING PHYSICIAN 20062239 JANUARY 01 2013 MARU NAING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEL-AIK, MD 21014 CARTAPORED HOSPITAL 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2 Day Year 2∏12 ρМ George Forst :00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Montgomery 9200 Potomac School Orive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Funeral Days Director 042-12-0164 1 X M 2 □ F Germany 4-10-1921 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-f show eny injury or other traumetic event, the Modical Exercitive court be not 174 at 10h Count 10c. City, Town or Location 10d. Inside City Limits Director Englewood Cliffs Bergen 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 07632 United States 2 Stephen Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. δ 1 Never Married 2 Married 1 X Yes 2 No WII Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Wholesale Toys Tovs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Thekla Alex Forst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gayle Forst - Daughter 750 Columbus Avenue, #3Y, New York, New York 10025 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Emerson Cedar Park Cemetery 12-30-2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Oanzansky-Goldberg Memorial Chapels rian Deibler 1170 Rockville Pike, Rockville, Maryland 20854 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Aspiration Pneummitis Pnysician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Dementia, Vascular Type or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events slcien and burial-trant Due to (or as a consequence of) resulting in death) Last ettending physicien for use as the buria Physician/Medical Diabetes Mellitus Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death the g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ą cate has been sig 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy Yes 2 X No 1 Yes 2 🗆 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be B 26. Place of Death (Check only one) Second Residence 6 KJ Other (Specify) Other: 4 Nursing Home 5 Residence ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this letely filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4 2013

Susan Miller, MD - 8218 Wisconsin Avenue, #305, Bethesda, Maryland 20814

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#9, 17 per FH, G935, 1/T17 2013, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aniceta Galpin 2012 1:10 A M December Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Davs Hours Country Philippines
Phillipines Director 038-38-1988 1 □ M 2 🗓 F 87 Apr. 23,1925 items 23a or 28a-f shover her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 United States 3152 Gracefield Rd. #315 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home other Be Page 1 and 2 should be filed verent of Health and Mental Hygant: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geminiano ည Lucina De Vera Procopio -Comiano and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Ford / Daughter 5310 Cutshaw Ave., Richmond, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or Chesapeake Crematory 01/02/2013 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Ligense 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MONTH Physician/ PULMONARY HYPERTENSION disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner (CHRONIC OBSTRUCTIVE PULMONARY DISEASE 4 YEARS Exquentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached. q | Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 X 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one, Other: 4XXXNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√√ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier t 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JULAINE HARDING CRNP. 3110 GRACEFIELD RD., SILVER SPRING, MD 20904 31. Date filed (Month, Day, Year) . Registrar's Signat State JANO 4 Registrar

12-10010 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Calvin Walter Gray State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Medical Examiner 0919 hrs December 30, 2012 Calvin Walter Gray Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death 1 Shasta Circle Apt E Owings Mills **Baltimore County** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) MD Months Days Hours Director 218-44-9216 7-29-1945 67 1X M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. Owings Mills Baltimore Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Shasta Circle, Apt. Е Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Armed Forces? 2 Married 1X Yes f Yes, Give Year or Dates: specifyAfrican-American 3 Widowed 1 Yes 2 No specify: 4 X Divorced <u>≨</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Elkridge Estates Laborer 1 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Greene Calvin S. Grav ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Shasta Circle, Apt. E., Owings Mills, MD 21117 Calvin W. Gray, Jr./Son 20a. Method of Disposition

1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place Garrison Forest Veterans 11-9-2013 Owings Mills, MD Donation 5 Other Specify 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 21. Signature of Funeral Service 9200 Liberty Road, Randallstown, MD 21133 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Physician/Medical x AMENDED#4a, per me, g936 1-26-13 sm UNPENDED Division of Vital Records, P.O. Box 68760, JE FEMALE 23c. If ves, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 2 Fetal death Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Liver Cirrhosis page 2 should be Completed 24a. Was an 24b. Were autopsy findings available autopsy pnor to completion of cause of death? performed? ✓ Yes 2 No 1 Yes 26.Place of Death (Check only one) 25 Was case referred to medical Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 🗸 Yes ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural 1 Yes 2 No 5 Pending filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 31, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 Harold Stanley Garner 7:25 ДΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg 11948 Bambi Court Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year) 212-20-2062 Director 1 M 2 D F 98 11-25-1914 Washington, DC Usual Residence of Decede 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MO Gaithersburg Montgomery 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 11948 Bambi Court 20878 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married ģ MMII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Scrap Metal 12 Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Annie Brenner Leo Garner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11948 Bambi Court, Gaithersburg, Maryland 20878 Felisa Carpio - Wife 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ò 1 K Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. B'nai Israel Cemetery 12-30-2012 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service cen ee Brian Oeibler 22. Name and Address of Facility Edward Sagel Funeral Oirection Xruan 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Aspiration Pneumonia Medical Due to (or as a consequence of) **Examine** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit **Hospital or Attending Physician**: The law requires that the death certificate be executed Cause (Disease or min) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 signed by the attending | d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery □ Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, cate has been sig , page 2 should b 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 🛭 O Hospital: Assisted Living 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide М Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. SignatOre and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Debrah Miller, CRNP - 1355 Piccard Orive, #100, Rockville, Maryland 20850

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 0

4 2013

R143201

12.28.12

			Ple	ease Type or					_		egible.	
			For	State	of Maryland				Mental Hy	giene	0 1 0	10767
			State Registrar			Certific	cate of D	Death		Reg. No.	012	42161
	Physicia	n/	1. Decedent's Name (First, Mic	O .	1.1		Glori	050	Date of De Month	ath Day	Year	3. Time of Death
	Medic	al	TONI	Olivia	•				1 7		2016	08129 M
	Examir	er	4a. Facility Name (if not institut		,			Location of Deal			nty of Death	nore
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia:	st birthday) If U	Inder 1 Year	If Under 24 Hrs	8. Date of Bir	th		place (State or Foreign
	Director		218-89-629	1 🗆 M 2 🗘 F	1	Yrs. Mor	nths Days	Hours Min	. (Month, Da	iy, Year)	Cour	itry)
	show dat		Usual Residence of Deceden		140.00				Jan 5	, 2011	1	rylana
	ryland I-f sh ied a	cto	10a. State 10b. Cour			Town or Location	Sm	rks	•			10d. Inside City Limits 1 ☐ Yes 2 💢 No
	he Marylar or 28a-f sl e notified	Dire	10e. Street and Number	altimor	e	10	f. Zip Code	1 10	T	10g. Citizen	of What Cou	
		Funeral Director	1519 Cold	Bottom	Boo	1	2	1152		Mait	ed S	States
	death with items 23a ner must b	ᆵ	11. Marital Status	12. Was Dec	edent Ever in U.S.	13. Was D	ecedent of Hi	spanic Origin? (S	specify Yes or No- to Rican, etc.)	14. F	Race - Ameri	can Indian,
98	s after des ral", or ite Examiner	[출	1 🕅 Never Married 2 🗆 N	If Voc Gi	orces? 2 No		es 2 🗖 No		to filoali, etc.)	Spec	Black, White,	etc.
ő	2 hours aft "natural", edical Exa	Completed	3 Widowed 4 Divorc	Year or D							W	rite
7	72 hc n "na Aedio	g	(Specify only hi	dent's Education ghest grade completed				ation <i>uning most of wo</i>	rking	16b. Kind o	f Business/Ir	idustry
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pu	filed valued by all Hyg		17. Father's Name (First, Middl	e, Last)	^ .			18. Mother's Na	me (First, Middle,	Maiden Surna	ame)	
_	# 3 ₹ ₹	입	Hnthony	David	Glor	1050		Car	ie Ly	un f	400	ver
Mar	shoul rand l		19a. Informant's Name/Relation		F	I.		\sim .	ural Route Numbe			
	1 and 2 sh of Health ar item 27 is other trau		Hnthony D.C. 20a. Method of Disposition	alorioso-		ace of Disposition		tom Kd	Date P		ryland on - City or T	d 21152
altimore,			1 Burial 2 N Cremati 4 Donation 5 Othe	on 3 Removal from	n State Ce	metery_cremator	or other plac	pel 1			1	
Ė	in tar in		21. Signature of Funeral Service		kund	Cremat	ne and Addres	S of Facility	$1 \alpha_1 \alpha \alpha \alpha \alpha$	rocest	e ITIII	Maryland
ñ	permi Depar Impor any ir	. 0	Stario	1 Spalu		169	AL TY	eraich	napel an	nktor	Man	m Services
			23a. Part 1. Enter the disease shock, or heart failure. Li	, or complications that	caused the death						/	Approximate Interval Between
_ P	hytician/		Immediate Cause (Final disease or condition	\(\text{Z}\)	05 N' TY	ا المحالفات	- (Lailu	re			Onset and Death
	Medical Examiner	П	resulting in death)	a. Due to	(or as a conseque	ence of):		-				
	LXUIIIIIOI	آر ا	Sequentially list conditions,	b	erre	nited.		isove				
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	00000	(Ur as a conseque	ence of):						
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09289	mcare ng phy as th	Med	IF FEMALE:									
<u>ن</u> ×	n cerr tendir or use	an/l	23b. Was decedent pregnant in the past 12 months?	1 🗀 Live	utcome of pregnar Birth 2 - Fetal	death 3 Ect		у			Date of deliv	*
Вох	e death certificate be the attending physic hed for use as the b	/sici	1 Yes 2 No	4 ☐ Pre 9 ☐ Unk	gnant at time of de known	eath 5 🗌 Oth	er (specify)				Month	Day Year
P.O.	law requires that the death cermicate be nas been signed by the attending physici e 2 should be detached for use as the bu	Ph	Part II. Other significant cond	litions contributing to	death but not resu	Iting in the underl	ying cause giv	en in Part I.	23e. Did 1	obacco use co	ontribute to t	the cause of death?
S,	signe d be	d by	Dev	dopre	what	Dal	~		1 🗆	Yes 2	3 □ Pro	obably 4 🗆 Unknown
ord	requ been shou	Completed					}		24a. Was	an 24	b. Were auto	opsy findings available
ec .	Ine faw ate has page 2 t	i i							auto perfe 1 \square Yes	psy ormed?	death?	ompletion of cause of
al F	s ician; The certificate irector, pag	Be C	25. Was case referred to medic	al			26. Pla	ace of Death (Ch		2 L= NO	i 🗆 fes	2 L NO
Zi.	nysici lis cel	2	examiner? 1 Yes 2 No	Hospital:	Inpatient 2 4	R/Outpatient 3	□ DOA Othe	er: 4 🗌 Nursing	Home 5 Resi	dence 6 \square (Other (Specif	ý)
of	Attending Physician; The refeath. ector: Affer this certificate he by the funeral director, page	ate:	27. Manner of Death 1 Natural 5 □ Per	/1.1-	e of injury nth, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe	how injury occ	curred	
ioi	death. ctor; Af y the fu	tific	2 Accident Inve	estigation	6 Indiana 0 A Indiana	N S forms of soft for		Yes 2 No	006 1	04		-I Doude Muselees
Division of Vital Records,	after Direc	Medical Certificate:	4 Homicide det	ermined 286. Plac build	e of Injury - At hor ding, etc. (Specify)	ne, iarm, street, ia	ictory, office		City or Tol		mber or Hura	al Route Number,
	spita hours neral y fille	ical		ring Physician: To the								
	In the hospital or Attending Physician; within 24 hours after death. To the Funeral Director, After this certifical completely filled in by the funeral director,	Mec	(Check 2 ☐ Medic only one) 3 ☐ Certify	al Examiner: On the ba ring Nurse Practitions	asis of examination er: To the best of m	and/or investigation y knowledge, deat	n, in my opinic n occurred at t	n, death occurred ne time, date and	at the time, date place, and due to	and place, and the cause(s) ar	due to the cand manner as	ause(s) and manner stated.
	10 t i		29b. Signature and title of cert	fier			29c. License	number	<u></u>	29d. Date sig		
0	<i>h</i>		- Cr			4	17	> 110	0	01	100	1/2013
	7		30. Name and address of pers	<u> </u>	use of death (Item		707	· N.	herles	St	Ball	51093 1003
1	Sta	te	31. Date filed (Month, Day, Yea	7) 32.	Registrar's Signatu	Ire de la constantina della co		1	1-1-1			
	Registr	ar	.IAN () 4 ZUIS	Lenew	10. 19	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

racey E Harpe		State of Maryland / Department of Partificate of L		Hygiene Reg. I	2012 42	768
Physici	an/	1. Decedent's Name (First, Middle, Last) Tracey Elizabeth Harper		2. Date of Death	3. Time of D	
Medical Exam	iner		City, Town, or Location of Dea	Month Da December 3	1, 2012 0741111 4c. County of Death	15
			Baltimore			
Funeral Director		3 , ,	If Under 1 Year If Under 24H Months Days Hours N	Ain. 10–30–196	MM/DD/YYYY) 9. Birthplace (State Foreign Country) MD) Of
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside 0	1
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with the Maryland ms 23a nr 28a-f sho be notified at once.	al Director	• · · · · · · · · · · · · · · · · · · ·	21215		Citizen of What Country? USA	
r death or ite	y Funeral		Decedent of Hispanic Origin? (, specify Cuban, Mexican, Pue es 2 No specify:		14. Race - American Indian, B White, etc. Specifican-Americ	
2 3	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 Nurse Assi	Usual Occupation (Give kind of of working life. DO NOT use ristant.	retired)	ib, Kind of Business/Industry	
5-0036 led within 72 Hygiene. other than "	Com	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid		
21215-00 nuld be filed wit Mental Hygien marked other c event, the M	Be	William T. Harper		A. Blake		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	٩		ngs Mill Way. Owi		r, City or Town, State, Zip Code)	
Fe, s 1 and of Heal If iten		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or other Metro. Crematory	on (Name of cemetery, place)	Date 20	Dc. Location - City or Town, State Baltimore, MD	
Baltimo permit. Page Department of Impurtant:		4 Donation 5 Other Specify:	,		kome P.A. of Baltimo	re Co.
	_2		Liberty Rd., Ran	dallstown, M	21133	
Physician Viedical	8 8	failure. List only one cause on each line. Immediate Cause (Final disease a Pulmonary Thromboembolism	node of dying, address cardia	c or respiratory arrest,	Between C	
Examiner		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b. Deep Venous Thromboses Due to (or as a consequence of):				
44	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			1	
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60, ate be e hysicia e burial	Wedical	LE SEAMS			23d. Date of delivery	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	cia	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal 4 Pregnant at time of death 5 Others	death 3 Ectopic preg	gnancy	Mo nth Day	Year
P.O. Bass that the degree by the educached is	y Physi		erlying cause given in Part I.		cco use contribute to the cause of	
S, P.C luires that n signed	ed by				2 No 3 Probably 4 ✔ L	
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should	Completed			24a. Was an autopsy performe 1 ✔ Yes 2	prior to completion of death?	
of Vital Rec og Physician: The After this certificate neral director, page	Be	25. Was case referred to medical examiner? [Hospital: A leastion 2 of ER/Outpetion 2	26.Place of Death (Chec		sidence 6 Other:	
Ing Phys After thi funeral d	2	1 V Yes 2 No Injury 28b. Time of Injury 28b. T		28d. Describe how		
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Divisi pital nr Ati ours after d teral Direct filled in by	ertifi	3 Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, for the determined (Specify)	actory, office building, etc.	or Town, State	et and Number or Rural Route Nur e)	nber, City
Division Tu the Hospital nr Attenswithin 24 hours after death To the Funeral Director:	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.				
F SF 3	ž	29b. Signature and title of certifier	29c. License number O.C.M.E.		ed. Date signed <i>(Month, Day,</i> Year) anuary 1, 2013)
5 M		30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Ba				
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regis		JAN 0 4 2013 June & Jacks ORIGINAL				
	-	COME				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No 1 Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MURISIK Sai TMOTE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** Days Months Min (Month, Day, Year) Director 217-50-3709 1 □ M 2 🖾 F 65 1947 22, Maryland Sep. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fem 27 is marked other than "natural", or itams on the trainment any Injury or other trainment. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Fallston Harford 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21047 USA 2845 Pleasantville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 ☐XNo Specify: Specify: 3

Widowed 4 □ Divorced USA Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Distribution Center 17 Warehouse Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roberts Virginia Augusta Rohrman (nmn) William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3147 Thornapple Court, Abingdon, Maryland 21009 Charlotte Spinner / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn. 1/3/2013 Bel Air, Maryland Signat eral Service Licenses 22. Name and Address of Facility McComas Funeral Home, P.A. 12 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ed by the a 9 Unknown tate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' this certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Watural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation Director: 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours after of Funeral Direct Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 012 31. Date filed (Month, Da) State 4 2013 JAN O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		Sta	te of Ma	aryland					and N	1ental Hy	giene	001	0	107	7 1
												Reg. No.	<u> </u>	4	421	11		
	Physicia		1. Decedent's Name		,		ŤΤο	al ma a					2. Date of De Month DEC	eath Pay	Ye	12	3. Time of De	
1000	Medic Examin		Ocie 4a. Facility Name (if		miltor give street an		HC	odges_	4b. City, To	own, or	Location of	of Death	DEC	4c. 0	County of E		10.50	/
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	Funeral	1	5. Social Security Nu		6. Sex 1 ☐ M 2	7. Age	(In yrs. las		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th	g.	Birthpl Counti	ace (State or F	oreign
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Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	2	Rob St C			on							(unk)					
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altimore,	t. Pag tmen rtant:		4 Donation	5 Other (Sp	ecify)		Fort						/2013			_	/irgini	_a
Bal	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		21. Signature of Fur		Deau	W			Name and				Comas F d, Abir)9
		П	23a. Part 1. Enter to	he disease, or o	omplications	that caused	the death.										Approximate Interval Betwe	
4	Physician/		Immediate Cause (Final	ny ene edace	IN	48c	ardi	al.	Tu	Lei	rct	ron				Onset and Dea	
The same	Medical Examiner		resulting in death)	4	P a. D	ue to or as a	conseque	ence of):	. /.	1	V	1	as cu la	1 7	7.			
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09	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director, After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical			d											_		
928	rtifical ing ph e as th	/Med	IF FEMALE:				,				_							
Box 687	eath certificate attending phy I for use as th	Physician/Med	23b. Was decedent in the past 12 in	months?	1 [es, outcome of Live Birth Pregnant at	2 🗌 Fetal	death 3 [Ectopic pr		у			2	3d. Date of Month		ry Day Y ea	ar
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Div	ital or urs aft ral Dir lled in					bullang, ord	. (0,000.13)							- Otate)				
	Hosp 24 hou Fune	Medical	29a. Certifier (Check 2	Medical Ex	aminer: On t	he basis of ex	camination a	and/or invest	igation, in m	y opinio	n, death o	ccurred at	d due to the ca the time, date	and place,	and due to	the cau	se(s) and mann	ner stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Σ	only one) 3 29b. Signature and	Certifying I	Nurse/Practi	oner: To the I	best of my l	knowledge, c			e time, date number	e and plac	e, and due to the		and manne signed (M			
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1-	,		30. Name and adding	ess o person w	ho complete	d cause of de	eath (Item 2	23a) (Type, P		1	111	1/	= /	/ / /	1/2		100	
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	Stat Registra		31. Date flee No.	4 2013	Clerk	22 Pegistr	s Signadu	ire					V					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 2012 CEMBER 11:45A PATRICIA ARLENE GRAWOH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK
If Under 1 Year I If Under 24 Hrs. FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 217-56-0237 Director 1 □ M 2 🗖 F 62 VIRGINIA Sept- 11,1950 th end Mentel Hyglene. 27 ie merked other then "neturel", or iteme 23e or 28e-f sho traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD FREDERICK 1 Yes 2 □ No FREDERICK 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral CEDAR CREST LANE 1509 21702 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☐ No Black White etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE 3 Divorced If Yes, Give Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) FAIRCHILD Elementary/Secondary (0-12) College (1-4 or 5+) DRAFTING ZNOUSTRIES 11 114 å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Baker Albert Haddie LOOKIHGBILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Cedar Crest Lane Walkersville, MD. 21702 f Heeith eltem 27 i ROBERT Howard 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 of Papertment of Papertment of Papertment: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State JAN 4,2013 SMITHSBURG CREM, SMITHSBURG MD, 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CARY L. ROLLINS FUNERAL HOME Rollin fray of. 110 WEST SOUTH ST FRED LRUK MD ZITOI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a feart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine signed by the ettending physicien end d be deteched for use as the burlei-transit Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 Unknown Chronic anemia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No To the Hoepitel or Attending Physicien: The within 24 hours after death.

To the Funerei Director: After this certificate i completely filled in by the funerei director, pag Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 0 4 2013

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hague

32. Registrar's Sign

DHMH 17 Rev 06-2011

700 Montchaire Ave

WD1 00

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	State of N		d / Depa	ndelible Inl artment of F <i>tificate of L</i>	Health		/lental Hy	giene	gible.	42773	
Physicia Medic		1. Decedent's Name (First, Middle, CATHY LOUISE				imedic of L	Joann		2. Date of Dea	Reg. No.		3. Time of Death 7:30 A. M	
Examin		4a. Facility Name (if not institution, 1803 SHIRLEY				4b. City, Town, or JOP		of Death			ty of Death		
Funeral Director		5. Social Security Number 213-76-4477 Usual Residence of Decedent	6. Sex 7. A	ge (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Day APRIL	h , Yea <i>r</i>) 5,1957	Coun	place (State or Foreign htry) ARYLAND	
aryland ta-f shov ified at	Director	10a. State 10b. County MD . HAR	FORD	10c. City	, Town or Lo		10d. Inside City Limits 1 ☐ Yes 2 🔀 No						
ith the M 23a or 28 st be not	ral Dir	10e. Street and Number 1803 SHIRLEY A	VENUE			10f. Zip Code 210 8	85			10g. Citizen o USA	f What Cour	ntry?	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Deceden	es? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, W 1 ☐ Yes 2 No Specify: Specify:							ack, White,	etc.	
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12 shoulc alth and N 27 is ma r traumat		19a. Informant's Name/Relationsh		ISE		ng Address (Street a			JOPPA,			Code)	
age 1 and ent of Hea nt: If item y or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 Removal from Sta	e c	eme <i>tery</i> , cren	sition (Name of natory or other place FAITH	ce)		Date -2013	20c. Location		own, State	
permit. P Departm Importal any injur		21. Signature of Funeral Service 1		GAK	22	. Name and Addres		ity SC		FUNER	AL HON	ME, INC.	
Physician/ Medical Examiner	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	d	2 Feta at time of d	death 3	Ectopic pregnanc Other (specify)	су				23d. Date of delivery Month Day Year		
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The law requ	Completed by								24a. Was a autop perfor 1 Yes	rmed?	. Were auto prior to co death?	psy findings available ompletion of cause of	
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thin 24 host the Fundampletely	Medical	(Check 2 Medical E only one) 3 Certifying	xaminer: On the basis of Nurse Practitioner: To	examination	and/or invest	tigation, in my opinion death occurred at t	on, de <i>a</i> th o the time, da	occurred at	t the time, date a ace, and due to the	nd place, and d ne cause(s) and	ue to the ca manner as	luse(s) and manner stated.	
P ≥ P 8		29b. Signature and title of certifier		M	D	29c. License	065	82	7	29d. Date sign	$\frac{1}{3}$	Day, Year)	
Stat	te	30. Name and address of person v	Kels	death (Item 507) trar's Signat	Upp	er Che	sap	eak	e Dr	Bell	ar,	MD 21014	
Registra		JAN 0 4 20	13 Secreta	A.	par								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 9:02 AM WILBUR EUSTACE HALL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death osedale Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Min. (Month, Day, Year) 5/15/1932 Hours Country)
WEST VIRGINIA Director 1 🕅 M 2 🗆 F 218-28-7722 80 or than "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5102 MCFAUL RD 21206 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced WHITE Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should e filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any hjury or other traumathe event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) MILLWRIGHT STEEL INDUSTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ JAMES HALL OPAL PERKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARJORIE HALL-WIFE 5102 MCFAUL RD BALTIMORE, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 12/31/12 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME Sexauco 9705 BELAIR RD NOTTINGHAM, MD 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events rcinoma and resulting in death) Last Due to (or as a consequence of): the attending physician ched for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 M Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' After this certificate Yes 2 2 No 1 🗌 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) |₽ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this
y filled in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 27 12 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year)

0.4

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nicholas Hozik, Sr. 3:00 P M Medical Dec 31, 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 13946 Brighton Dam Rd Howard Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Director N 2 □ F 211-12-6959 ጸጸ Dec 7, 1924 Usual Residence of Deced then "natural", or items 23a or 28e-f show the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene.
Item 27 is marked other then "natural", or items 23a or 28e-1 show other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Clarksville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13946 Brighton Dam Rd. 21029 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 6/16/1943 If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates 4/22/1946 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Corporate Executive **Property Management** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ George Hozik Katherine unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicholas Hozik, Jr. Son 13946 Brighton Dam Rd. Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Importent: If it eny injury or of once, Mt. Zion United Methodist Jan 08, 2013 Highland, Maryland 21. Signature of Funeral Service/Licens 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury l or Attending Physicien: The law requires that the death certificate be executed after death. the burial-tran Due to (or as a consequence of) attending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops certificate ☐ Yes 2 🕽 1 ☐ Yes 2 ☐ No 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one, 1 🗌 Yes 2 DxNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Director; After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funerel Di completely filled in Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certific s of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year, 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ha11, Sr. Charles Henry Physician/ Month Day Year 12:05P M 2012 Medical Dec 30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2825 Wells Avenue Edgemere Baltimore Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 219- 28-2016 Director 1 ☑ M 2 ☐ F 79 Yrs Sept.9,1933 Maryland ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Baltimore Edgemere 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2825 Wells Avenue 21219 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. Š 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'am jujury or other traumatic event, the Means injury or other traumatic event, the Means Elementary/Secondary (0-12) College (1-4 or 5+) Allied Maintenance Allied Maintenance Owner 8 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bessie E. Chester George Robert Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2825 Wells Ave. Edgemere, Maryland 21219 Brenda C. Schultz (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/3/2013 Baltimore, Maryland Oak Lawn Cemetery 4 Donation 5 Other (Specify) 21. Si wature of Funeral Service Liperpee Denvils Catroll Butta-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician CHRONIC OBSTRUCTIVE PURMONARY disease or condition resulting in death) Medical Due to (or as a consequence of): [∡]Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Vaa 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? or Attending Physician: The law To the Hospital or Attending Physician: The law within 24 hours after death.
To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No <u>م</u>| 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature #Ind title of certifier 29d. Date signed (Month, Day, Year) DECEMBER 31, 2012 D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD BACTMORE, MD 21236 C. WALEACE BRIAN MA

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 4 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 31, 2012 Helena Mollie Hahn 12:10 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. (Month, Day, Year) 220-24-8187 **Director** 1 □ M 2 🔀 F 83 2/6/29 Usual Residence of Decedent Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 √Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1256 James Street 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other n other traumatic event, 姓 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Blizzard Freda Albaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau William L. Hahn Jr. / Son 1256 James Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State orraine Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1/5/13 Baltimore, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List party one cause on each line. Immediate Cause (Final Physician/ 2 P D 47 5 Cartinone disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Venous Thrombos's 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) within 24 hours aft

To the Funeral Dir

completely filled in 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Yim MD, 821 N. EutawSt. #301, Baltimore, MD 21201 State Registrar X DHMH 17 Rev 06-2011

ORIGINAL

Box 68760 Baltimore, Maryland 2

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			30. Name and address of person who c	ompleted cause of d	eath (Item 23a	0 1	(s)									
	Stat		31. Date filed (Month, Day, Year)		ar's Signature		1.1								<u> </u>	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAHN If Under 1 Year MANOR Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**X**XM 2□ F 76 Baltimore, Maryland November 21,1936 Director 218-32-5591 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examinal must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo Harford Edgewood Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 702 Dogwood Dell Court 21040 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status TYYes 2 ☐ No Yes, Give 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Computer Programmer Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Hales, Sr. Mae Mumma ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valerie Schaub (Daughter) 704 Cedar Crest Court, Edgewood, Maryland 21040 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Date 20a Method of Disposition January 04, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Cameris Name and Address of Facility Signature of Fluneral Service Licenses Evans Funeral Chapel & Cremation Services-Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner rtensic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine requires that the death certificate be executed and Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending | IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 mgaths? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No P.0. ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 **VN**0 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After t Certification: To the Hospital or Attending 5 Pending investigation 1 Natural 1 □Yes 2 □ No within 24 hours after death. To the Funeral Director: ₽ 2 Accident completely filled in by the 6 Could not he 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

UN

State Registrar

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31. Date filed (Month, Day,

32. Registrar's Signature

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30. Name and address of person who completed cause of death-(Item 23a) (Type, Print)

Year)

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Donald Lee Ingram December 19:39 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimole Hospital N/A 105 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) Director 219 66 6255 1 🛛 M 2 🗆 F 58 Yrs 10/21/1954 Maryland show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 shoury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 811 Edmondson Avenue 21228 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No 3 Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self employed Musician Music vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Allison J. Ingram, Sr. Anna Mae Whittington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryann Ingram / Wife 811 Edmondson Avenue Baltimore, Maryland 21228 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Injury o 01/07/2013 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service. P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mamer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition acute MYOLAT Medical resulting in death) Due to (or as a consequence of Examiner hypertension Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year signed by the at Yes 2 No 9 Unknown q ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? his certificate has bal director, page 2 sl 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 R/Outpatient 3 IDOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 66108 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (A

Ingram,

900

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of	Marylan				and M	lental Hy	giene	9 0	10	10701
			Registrar 1. Decedent's Name (First, Middle,	l ast)		Cen	tificate o	Death		2. Date of De	Reg. No	o.	16	3. Time of Death
	Physicia		James D. Jac	,						Month Decemb	, Da	Day Year Crice a		
	Medic Examin		4a. Facility Name (if not institution,		per)		4b. City, Towr	n, or Location		020811)1)		c. County of		
~ <	£		VA Maryland A	tealth Car	e 5457	em	Perry	Poin	1			Cec	cil	
	Funeral		5. Social Security Number	5. Sex 7	7. Age (In yrs. la	st birthday)	If Under 1 Xe Months Da		24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birthpl Countr	ace (State or Foreign	
	Director		218-46-6129 Usual Residence of Decedent	1 🖾 M 2 🗆 F	65	Yrs.			- 1	Jan. 7		947	Arkaı	nsas
	and show	ō	10a. State 10b. County		10c. City	, Town or Loc	ation						10	d. Inside City Limits
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	h the Baor	a D	10e. Street and Number				10f. Zip Cod	е			10g. C	itizen of Wh	nat Count	ry?
	th wit	Funeral Director	515 Broad Str			l en er	2190					SA		
	r dear	by Fu	11. Marital Status 1 Never Married 2 Married Married 2 Married Married Married 2 Married Ma	12. Was Deced Armed Ford 1 🔀 Yes	ces?	i. 13. W	as Decedent of Yes, specify C	if Hispanic Ori uban, Mexicar	igin? (Spe n, Puerto l	city Yes or No- Rican, etc.)		14. Race - Black,	- America White, e	
<i>D.</i> 215-0036	s afte rai",		3 Widowed 4 Divorced	If Yes, Give Year or Dat		1	☐ Yes 2🛣	No Specify:	:			Specify:	W	hite
5-0	hour	Completed	15. Decedent (Specify only highes			16a. Deced	ent's Usual Oci	cupation	t of working	na .	16b. I	Kind of Busi	iness/Ind	ustry
	hin 77 ne. than	E	Elementary/Secondary (0-12)	College (1-4	4 or 5+)	life. DC	NOT use retir			.9	Γ,	,		
N 0	filed within 72 hours after death with the Maryland at Hygiene. 3 other than "natural", or items 23a or 28a-f sho went, the Medical Evarrither must be notified at	Bec	17. Father's Name (First, Middle, La	st)		(Unkn	own)	18 Moth	er's Name	(First, Middle,	-	unknot	wn)	
Tume, yland	be fill ental ked c	2	John Worthingto	,	n					Claudia				
Jumes aryland 21	should be h and Menta 7 is marked raumatic e		19a. Informant's Name/Relationshi			19b. Mailin	g Address (Stre	et and Numbe	er or Rural	Route Numbe	er, City o	r Town, Sta	te, Zip Co	ode)
CE	nd 2 sealth am 27 i		Mark Carroll /	Guardian		145	N. Hick	ory Av	re.,]	Bel Air	c, Ma	arylaı	nd 2:	1014
Jackson Baltimore, I	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mestical Evarither must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from S	State Co	emetery, crem	ition (Name of atory or other p	olace)		ate	l	_ocation - C	•	
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Ba C	permit. Departr Imports any inju		21. Signature of Funeral Deprice	EM-			Name and Ad 317 Col							nd 21009
			23a. Part 1. Enter the disease, or o shock, or heart failure. List on	omplications that cally one cause on each	aused the death	n. Do not enter	the mode of o	lying, such as	cardiac o	r respiratory ar	rrest,			Approximate Interval Between
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687	entifica ding p	Ψ.	IF FEMALE:	23c. If yes, outc	ome of pregnar	ncv						20 1 5	f 1 F	
Box 687	atten affor u	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 🔲 Live B	irth 2 ☐ Feta ant at time of d	Ideath 3 🗌	Ectopic pregn Other (specify				Ĭ	23d. Date Mont		ry Day Year
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æ	n: The licate rr, pag		25. Was case referred to medical							1 🗌 Yes	ormed?		Yes :	2 🗆 No
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o £	g Phy erthis neral o	ië F	27. Manner of Death	28a. Date o		28b. Time of injury	28c. lr	njury at vork?		me 5 🗌 Resi 28d. Describe I				
o u	eath. or: Aff the fu	ifica	1 Matural 5 Pending 2 Accident Investiga 3 Suicide 6 Could n	ation			M 1	☐ Yes 2 ☐] No					
Division of Vital Records,	or Att	Certificate:	4 Homicide determin	28e. Place o	of Injury - At ho g, etc. (Specify)	me, farm, stre	et, factory, offic	ce	1	28f. Location (City or To			or Rural I	Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 🔀 Certifying I	Physician: To the be	st of my knowle	edge, death o	ccurred at the	time, date and	place, an	d due to the c	ause(s) a	and manner	as state	d.
	the Hc in 24 the Fu	Medical	(Check 2 Medical Ex	aminer: On the basis Nurse Practitioner:	s of examination	and/or investi	gation, in my o	pinion, death or	ccurred at	the time, date a	and place	e, and due to	o the caus	se(s) and manner stated.
	Veit Veit Con		29b. Signature and title of certifier	1				ense number	a.			ate signed (
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2+1			30. Name and address of person w Suresh Shande		of death (Item	23a) (Type, Pr	int)	L Con	0 5 11	ton	Poni	N/ Rail	+ m	aryland
0	Sta	le	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	ure 2	115411	m. Care	z zys	116111	16-11	7 1011	113/6	ar yrand
	Registra	ar	JAN 0 4 2013	Russia	B. 1	arks								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perff, G935, 17472013, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15.2 Elizabeth ember Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 0 MOY UTT 5. Social Security Number 215-30 - 793 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Director 1 M 2 V F 76 Yrs. 6-8-36 13A MD 10 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show injury or other traumatic event, the Medicel Evariant must be notified at any linus or other traumatic event, the Medicel Evariant must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1timore 1 No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA KOAO 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? / Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 00 MARMACU Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Bel Obert TUN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) John Nelson UShawa 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 V Cremation 3 Removal from State HANOVER MT 4 ☐ Donation 5 ☐ Other (Specify) Vaugho C. Creene RANDAIlSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician anemia onli Medical Due to (or as a consequence of): Examiner troinlestina Sequentially list conditions, if any, leading to finite liate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence oi). After this certificate hes been signed by the attending physiclan and funeral director, page 2 should be detached for use as the burial-transit or Attending Physicien: The law requires thet the death certificete be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Completed angibali 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Director: A d in by the f Investigation 6 Could not be To the Hospital or Atter within 24 hours after ded To the Funerel Director completely filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2012 cember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 2435 W. Belvedere tve. Ste 42 Smith CRNP auren 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8 Per FH G935 1/09/2013 III
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Name (First, Middle, Last) 3. Time of Death 2. Date of Deat Physician/ Mechember 29 Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner schear timore If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day) Yeal 935 Birthplace (State or Foreign Country) Funeral 1 M 2 - F Director Pega 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth end Martel Hyglena. ant: If Item 27 is marked other than "natural", or Items 23a or 28s-f sho 10b. Count Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director atonsville 1 Yes 2 XXIIo 10e. Street and Nu 10g. Citizen of What Country? enue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during life DQ NOT use retired) College (1-4 or 5+) Be ၉ a Dapertment of Haelth er Important: If Item 27 is any injury or other trau Jones atonsville ethod of Disposition 20b. Place of Disposition (Name of 1 ★Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service License 23a. Part 1. Enter freedisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heal dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Mospital or Attanding Physician: Tha lew raquires that the deeth cartificata ba exacuted within 24 hours effer deeth.

To the Funerel Director: After this cartificata hes bean signed by the ettanding physician end complataly filled in by the funeral director, pega 2 should be datached for usa es tha burlei-trensit Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No

9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 25. Was case referred to medica 26. Place of Death (Check only one) Other: ٩ 1 🗆 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending _ Investigation 1 Natural 2 Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) at 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one DIKANKANALA 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type, Print) Wood 31. Date filed (Month, Day, Year) State JAN 0 4 2013 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				for State Registrar		,	Certificate of			ı. No.	
		Physicia Medic		1. Decedent's Name (First, Middle Anna Be	11'	nson			2. Date of Death	70ay 2012	2336 M
	~	Examin	er	4a. Facility Name (if not institute	4c. County of Dea	ath					
		Funeral Director		5. Social Security Number 250-18-7810 Usual Residence of Decedent	6. Sex 7.	. Age (In yrs. lasi	t birthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yo	9. Bi	rthplace (State or Foreign buntry)
		and ehow	호	10a. State 10b. Count	у		Town or Location		.,,.		10d. Inside City Limits
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		h with the	Funeral Director	196. Street and Number	ale Street	et	10f. Zip Code	229		g. Citizen of What C	ountry?
	900	72 hours efter death with the Maryland n "neturel", or items 23a or 28e-f eho Andlost Examiner mest be motified at		11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	ed If Yes, Give Year or Date	es? No	13. Was Decedent of In If Yes, specify Cub	an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
	21215-0036	the the	Completed by	(Specify only high Elementary/Secondary (0-12)	lent's Education hest grade completed) College (1-4		16a. Decedent's Usual Occup (Give kind of work done life. DS NOT use retired,	during most of worki	ing 10	6b. Kind of Business	s/industry
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0	Baltimore,	Page nent o ant: If ary or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 Removal from St (Specify)	tate Cen	ce of Disposition (Name of netery, crematory or other pla	er 1/7	2013	Baltima	r Town, State
W	Bal	permit. Departr Import. eny inje		21. Signature of Funeral Service	Licensee Theen	۰	515178	is of Catility Grand	eene Fi	Pike	Services (21229)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Day 21 Physician/ 2012 Jayant Singh Kalotra 1902 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1902 Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours Days Min. (Month, Day, Year) **Director** 088-68-4630 73 09/15/1939 Former India or 28e-f shov 10a. State 10b. County death with the Maryland Injury or other treumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo VA Fairfax McLean 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera or items 23a 1449 Woodhurst Blvd 22102 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify should be filed within 72 hours after and Mental Hygiene.

is merked other then "naturel", Specify: White 3 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Management Consultant International Development æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Zorawar Singh permit. Page 1 and 2 should be Department of Health and Men Importent: If item 27 is merke eny Injury or other treumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amrit K. Kalotra - Spouse 1449 Woodhurst Blvd. McLean, VA 22102 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗌 Burial 2 🖾 Cremation 3 🗍 Removal from State National Crematory Falls Church, VA 12/24/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Falls Church National Funeral Home 7482 Lee Highway, VA 22042 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ 5055 Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events 500 coma burial-tran Exa and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the the as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months? Day 2 No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Bladder cancer Completed been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Colon cancer 24a. Was an page 2 s has autopsy performed? Yes 2 2 N Diabetes llitus this certificate director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 X 100 မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check WD 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year 41169 0gr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20874 1529 Doctor mp Ganti

Registrar

State

31. Date filed (Month, Day, Year)

JANO 4 2013

32. Registrar's Signature

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	Funeral		5. Social Security N	umber 6.	Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days				9. Bi	irthplace (State or Foreign ountry)	
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	Maryland 28a-f show officed at	ctor	10a. State MD	10b. County BALTI	MODE	10c. Ci	ty, Town or Lo	cation SVILLE					10d. Inside City Limits 1 ☐ Yes 2 🛱 No	
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Division of Vital Records,	To the Hospital or Attending Physician: The law require within 24 hours and refeath. To the Funeral Director. After this certificate has been significate the funeral Director. After this certificate has been significant	Complete								per	s an opsy formed?	prior to death?	uttopsy findings available completion of cause of	
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	Hospi 24 hou Funer stely fill	Medical	(Check 2	Medical Exa	miner: On the ba	sis of examination	on and/or inves	tigation, in my opin	ion, death oc	place, and due to the courred at the time, date	cause(s) a and place	nd manner as	stated. e cause(s) and manner stated.	
	To the within To the comple	Σ	only one) 3 29b. Signature and		urse Practitione	r: To the best of	my knowledge	29c. Licens	se number	te and place, and due to		te signed (Mon		
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			30. Name and addr	ess of person wh	o completed cau	se of death (Iter	m 23a) (Type, I	rint)	Balti	more MO	212	09-		
	Sta Registr		31. Date filed (Mont		013	Registrar's Signa	ature		··········					
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State of Maryland / Department of Health and Mental Hygiene

for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 19:45 **Physician** 2012 12 31 Marvin Kopit /Medical 4c. County of Oeath 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Months 1**X** M 2 □ F New York 114-30-9993 72 1-4-1940 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Madical Examinar must be notified at 1 Yes 2 □ No Director Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 5800 Nicholson Lane #2N8 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W ☐ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 🕱 No Specify. White Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mental injury or other traumatic event, the Mental College (1-4or 5+) Elementary/Secondary (0-12) Education Professor/Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Gecht Julius Kopit ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5800 Nicholson Lane, #208, Rockville, Maryland 20852 Carole Kopit - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Paramus New Jersey 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Park Cemetery 1-3-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Edward Sage1 Oanzansky-Goldberg Memorial Chapel 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hini **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Oate of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) signed by the signed by the signed for the signed f □Yes 2□No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No 1 ☐Yes 2 No 1 ☐ Yes certificate To the Hospital or Attending Phystcian: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of eath
1 Natural
2 ☐ Accident 28c. Injury at Work? 5 Pending 1 □Yes 2 □No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 lanist 32. Registra 31. Date filed (State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12 Year 2012 Terrie Leigh Kelley 3:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 201 Contour Rd If Under 1 Year If Under 24 Hrs. Frederick 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Months Country) Arizona Davs Hours Min. (Month, Day, Year) 12/22/1959 Director 1 □ M 2 🗗 F 547-27-7456 53 Yrs. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Funeral Director 1X Yes 2 No MD Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Contour Road 21771 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 X Yes 2 ☐ Mair Force Black, White, etc. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene: Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. Year or Dates. 1977-87 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Buckler Unkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelby Kelley / Daughter 201 Contour Road, Mt. Airy, MD 21771 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/4/2013 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ CANCER UNG Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate! performed? Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 1 🗌 Yes 2 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🔊 Natural injury 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 29c. License numbe 29d. Date signed (Month, Day, Year) MD 072139 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q. ABBOX MD 6336 Drumbia CEDAR

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JAN 0 4 2013

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	ase Type or	Print in	n Black	k Indeli	ble Inl	k. Ensure	All Copies	Are Leg	ible.	
		For State		State o	f Maryla					Mental Hygi	ene 20	12	42789
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Funeral Director		374-16-8.	308	6. Sex 1 🛛 M 2 ☐ F	7. Age (In yr.		Months		Hours Min.	8. Date of Birth (Month, Day,) April 6	^(ear) 1924		place (State or Foreign try) Chigan
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be filed within 72 hours ental Hygiene. ked other than "natura c event, the Medical E	To B	17. Father's Name (Fil		Last) Liam P. Li	ttl ow	nad			18. Mother's Nar	ne (First, Middle, Ma Ada Grú		e)	
2 should be filed within 72 hours th and Mental Hyglene. 77 is marked other than "natura traumatic event, the Medical E		19a. Informant's Nam					Mailing Addre	ss (Street	and Number or Ru	ral Route Number, C		tate, Zip C	Code)
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permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.			Cremation	3 Removal from	State	cemetery,	Disposition (Na crematory or	other plac			0c. Location -		
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		shock, or heart	failure. List of	complications that conly one cause on each	ch line.			•	_				Approximate Interval Between
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Physic this c	မ	1 Yes 2 2 27. Manner of Death	No	Hospital:	·	ER/Outp	patient 3 🗆	DOA Othe	4 Let Nursing H	ome_5 Residen			. ,
r Attending P ter death. rector: After t by the funera	icate	1 Natural 2 Accident	5 Pendir	ng (Mont	h, Day, Year)	inju		work		28d. Describe how	injury occurre	ea	
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu		29a. Certifier 1	Certifying	Physician: To the be			eath occurred	at the time	date and place a			er as state	d
he Hos in 24 h he Fun pleted	Medical	(Check 2 L	⊒ Medical E	xaminer: On the basi Nurse Practioner: 1	s of examina	tion and/or i	nvestigation, i	n my opinic	on, death occurred	at the time, date and	place, and due	to the cau	use(s) and manner stated.
Vith To th	-	29b. Signature and titl			/	0.	29	9c. License	e number	29 λ	d. Date signed	(Month, E	Jay, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month la Physician/ LANGELLUTTO 04:45 AM Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Good Samartan HOSPITA O Baltimore 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Month, Day, Year) 1941 Hours Pennsylvania Director 214-38-8208 1 M 2 T F 71 l and 2 should be filed within 72 nous a..... f Health end Mental Hygiene. Item 27 is marked other than "netural", or Items 23a or 28a-f show Item 27 is marked other than "netural", or Items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10o Citizen of What Country? Funeral 21234 USA 1801 Wentworth Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 2 1 Never Married 2 Mamed 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Bally's Casino room service dispatcher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Jane O'Neil Francis Wise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 9th St; Ocean City, NJ 08226 Vincent J. Langellotto - husband or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Depertment of H Importent: If Ite eny Injury or ot once. 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify)in state . Signature - Funeral Service I cens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Iremia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury for use es the burial-trensit or Attending Physician: The law requires that the death certificete be executed Metabolic secondary to Uremia acidosis that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 📈 No 9 ☐ Unknown Day Pregnant at time of death ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate hes been signed page 2 should be de 2 Melitus, Renal coll caranoma 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Colorectal cancer. autopsy certificate breast 1 Yes 2 No 1 ☐ Yes 2 🔀 No comean, Coronan 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 0000

DHMH 17 Rev 06-201

Registrar

Blud.

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601

Loch

Tewolde

Selam

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perpHYS#19a, perFH, G950, 4/9/2014, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death Decedent's Name (First, Middle, Last)

Dorothy Mae Hamilton Myrick

Dorothy Mae Myrick 2. Date of Death Physician/ Month Year 8:20 A 2012 Dec. Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2140 Brooks Drive #405 Prince George's District Heights Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours (Month, Day, Year) Director 1 □ M 2 💢 F 578-54-5201 69 Jan. 19, 1943 Washington, DC Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Prince George's District Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 20747 USA 2140 Brooks Drive #405 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. ģ 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government 12th <u>Postal Service</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Clark Mims Hamilton Emma Eliza Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Ashaki Myrick/Sister Lubbock Road, District Heights, MD 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 1/3/2013 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hyperlipidemia Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Hyperthyroidism the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an is certificate has be director, page 2 s autopsy performed? Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 10 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) n 24 hours after ueau... ne Funeral Director: After th maletely filled in by the funera Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Marse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D8397 January 2, 2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 10274 Lake Arbor Way #202 Mitchellville, Maryland 20721 Norman McKoy MD 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 0 4 2013

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

144 State of Maryland / Department of Health and Mental Hygiene 12-09834 Steven Matysek Certificate of Death 1- For State Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day December 25, 2012 0804 hrs Steven Gregory Matysek Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2715 Long Meadow Way 2715 Long Meadow Dr Harford Abingdon 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Hours Months Days Director CountryMaryland 1967 May 8, 45 213-04-4488 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show s 23a nr 28a-f show e notified at once. Maryland Harford Abingdon Director hours after death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2715 Long Meadow Drive 21009 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. more, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death without of Health and Mental Hygene.

ant: If it fites 27 is marked other than "natural", or item; or other traumatic event, the Medical Examiner must be a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White 1 Yes 2 No specify: Specify: If Yes, Give Year 3 Widowed 4 Divorced 2 Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Residential College (1-4 or 5+) Elementary/Secondary (0-12) General Construction Construction 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Theresa Catherine Buczek Albert Ernest Matysek Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ 19a. Informant's Name/Relationship (Type, Print) 2715 Long Meadow Dr., Abingdon, Maryland 21009 Kristi Kae Matysek / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 12-31-2012 Bel Air, Maryland Department o Rose Hill Svcs, LLC Donation 5 Other Specify McComas Funeral Home, P.A. pature of Funeral Service Licer 22. Name and Address of Facility injury 1317 Cokesbury Road, Abingdon, MD 21009 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Ent **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Contact Gunshot Wound of Head Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit x AMENDED 28a, per me, g935 1-29-13 sm Physician/Medical UNPENDED e attending physician for use as the burial 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.O. 1 Yes 2 No 3 Probably 4 Unknown ۵ Completed of Vital Records, 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed Yes 2 ✔ No 2 No page 26 Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 🗸 Other: Scene examiner? Hospital: 1 Inpatient DOA 2 ER/Outpatient 3 this 2 No 1 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury After 27. Manner of Death Subject shot self FOUND 12-25-12 Certification Natural FOUND: 1 Yes 2 ✔ No Division n 24 hours after death ie Funeral Director: A letely filled in by the fi Pending 0757 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide Could not be or Town, State) 2715 Long Meadow Way, Abingdon, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 Ta the 1 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier December 26, 2012 O.C.M.E. allan 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol H. Allan, MD 32. Registrar's Scinature State

DHMH 17 Rev 1/2001 0 CME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 1 Physician/ 29, 2012 Irving Marvin Morganstein 12:08A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Mar 16, 1928 Days Hours Min. Connecticut Director 043-22-5862 1 M 2 🗆 F 84 e filed within 72 hours after death with the Maryland tal Hygiene. do do do do then than "natural", or items 23a or 28a-f showed of the Medical Examinar must be natified at event, the Medical Examinar must be natified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12100 Old Bridge Road 20852 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Armed Forces Black, White, etc. Š 1 Never Married 2X Married ☐ Yes 218 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Maintenance man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith end Mental H 27 is marked of traumatic ever e 1 and 2 should be fill of Health end Mental If Item 27 is marked or other traumatic eve Jennie Kronish David Morganstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12100 Old Bridge Road Rockville, MD 20852 19a. Informant's Name/Relationship (Type, Print) Naoma Morganstein/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Final Journey Crematory 01/03/13 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service Licen-Going Home Cremation Service P.O. Box 784 51Beverly 1. Heckrotte, P.A. Clarksville, MD Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ a Arteriosclerotic Heart Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): cate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be 68760 IF FEMALE yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death
☐ Some of the control of t 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an performed? Yes 2 XN Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No 유 1 Inpatient 2 XER/Outpatient 3 I DOA ð 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) (V, M)30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgetown No OLD BRENDON CARMODA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State park Registrar

DHMH 17 Rev 06-2011

WORGANSTEIN,

29/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 5:50 PM larvin Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Brooklyn Baltimore Genesis - Hammonds Lane Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Nov 9, 1924 Days Hours Country) Director 240-30-8308 1 🔀 M 2 🗆 F 88 North Carolina item 27 is merked other then "naturel", or items 23a or 28e-f show other treumatic event, the Medical Everging must be notified at 10a, State 10b. County 10d. Inside City Limits 10c. City, Town or Location death with the Maryland Director 1 ☐ Yes 2 🖾 No Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21225 1014 Chevy Hill Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 1943 — Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after black If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. 1962 Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) research Be 17. Father's Name (First, Middle, Last) permit. Pege 1 and 2 should be filed Department of Health and Mental Hy importent: If item 27 is merked otherny Injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Surname) ဥ Knox Brandon Watson McClean 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Chevy Hill Rd; Baltimore, MD 21225 19a. Informant's Name/Relationship (Type, Print) Mary McClean - wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 Remoyal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Sovice ice Tede, 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1\Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician myocardia Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physicien: The law requires thet the death certificate be executed Due to (or as a consequence of): resulting in death) Last been signed by the attending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Day Year be deteched 9 Unknown Part I<mark>I. Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 含 1 Yes 2 No 3 Probably 4 Unknown Completed disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ron hes anemia After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to 8 26. Place of Deat Check only one) examiner? Other: 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No ☐ Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined Medical

within 24 hours after death.

To the Funerel Director: A completely filled in by the fi

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier

(Check

only one 29b. Signatu

enni

and title of certif

30. Name and address of person who completed

cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Flizabeth C. Musotto 31,201 December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Centler Baltimore Towson If Under 1 Year If Under 24 Hrs Months Days Hours Min Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) 214-30-3625 77 Director 1 □ M 2 🗓 F 1935 29 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If item 27 is marked other then "nature!", or items 23e or 28a -f shown injury or other traumatic event, the Mydical Experiment invative notified an once. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Baltimore Cockevsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21030 U.S.A. 815 Stafford Shire 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by timore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Government Buyer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Butler Elizabeth Patterson Arthur 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 2 Bromwell Court, Cockeysville, Maryland Karen Bolewicki / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GardensOfFaithCem. 1/5/2013 Baltimore, Maryland 21. Signature of Fundal Same Fice 22. Name and Address of Facility Ruck Towson Funeral Home Towson, Maryland 1050 York Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sequential in death Last Examine Due to for as a consequence of or Attending Physician: The lew requires that the death certificete be executed attending physicien and I for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year signed by the af 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🛕 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performed 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) funeral 27. Manner ath 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural Accident 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No death. Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32. Registra 's Signat State Registrar X DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Month Day Year Jecum Per 30 7012 Physician/ Mainen e/e 6745 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) Director 219-18-6653 1 □ M 2 🗓 F 88 03/23/1924 MD Usual Residence of Deced 2 should be filed within 72 hours once.
thend Mentel Hygiene.
27 is merked other then "neturel", or Items 23a or 28e-f show 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 V No BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3410 ASSOCIATED WAY, #202 21117 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🕅 No Š Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry st grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LOUIS SCHOEN REBECCA LUNTZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 st at of Heelth e : If kem 27 k IRA ANSLOW/SON-IN-LAW 8032 UPPERFIELD COURT, OWINGS MILLS, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Importent: If It eny Injury or o 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MARYLAND VETERANS CEM 01/08/2013 OWINGS MILLS, MD 21. Signatury of Funeral Survice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physicien end I for use es the burial-transi The law requires that the deeth certificete be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death Other (specify) been signed by the eshould be detached g 🗌 Unknown P. 0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Triknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan page 2 performed? 1 Yes 2 🗌 No Yes 2 N Hospitel or Attending Physiclen: funerel director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other:
4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No s after deeth.

I Director: After this cad in by the funerel director. ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or A within 24 hours after To the Funerel Direc completely filled in by Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of cer D0053337 30 2012 e comber

Registrar
DHMH 17 Rev 06-2011

State

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ O'Connor, December 2012 Gregory Aloysius 4:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Homecrest Assisted Living Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) **Director** 213**-**12-1440 1 XM 2 □ F 93 Yrs Nov. 29, 1919 Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 414 Penwood Rd. 20901 United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian was becedent Ever in 0.5
Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates. ₩ • ₩ • Black, White, etc. δ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural", 1 ☐ Yes 2 X No Specify: 3 ₩ Widowed 4 Divorced Specify: White Completed ΙI 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gregory O'Connor Ellen Mary Deady permit. Page 1 and 2 should t Department of Health and Me Importent: If item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick M. O'Connor Son 5617 Pier Dr., Rockville, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven Cem. 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Injury or 01/03/2013 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²² Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Ž. 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consquerc Exami physician and the burial-transit or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiclan I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Records, Completed 1 Tes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s has autopsy perform this certificate 1 ☐ Yes 2 🕅 No **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 12 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 \$ LIVING To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. Other (Specify) 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OX

State Registrar

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Medical 4a. Facility Name (if not institution, give street and number) AAMC Maryland Primary Care 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Maryland Anne Arund Annapolis Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex ZAge (In yrs. last birthday) 8. Date of Birth **Funeral** Months (Month, Day, Year) **Director** 1 🔀 M 2 🗆 F 219-12-3523 87 Maryland Jan 14, 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a event, the Medical Examiner must be Funeral 21401 USA 805 Coxswain Wax Unit 103 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No Specify: 3 ☐Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) be filed within C&P Telephone field engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Hazel Estelle Dawson Richard Alvin Owens Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 670 W. Central Ave; Davidsonville, MD 21035 Richard Owens III - son 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othe (Specify) 22. Name and Address of Facility State Anatomy Board Darector 655 W. Baltimore St; Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** espirator Sequentially list conditions, Examiner Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? prostate Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) romw 9 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December Paquin 3:03 P M Nancy 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Hours Director 009-26-5764 1 □ M 2 🛣 F 73 Nov. 3, 1939 Vermont I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 112 Central Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. þ 1XXNever Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2121 Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Computer Administrator Federal Government Be and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alice Gardner Raymond Paquin, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19001 Muncaster Rd., Derwood, MD Jan Rueter / Executor lore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory 01/03/2013 Beltsville, MD 22 Name and Address of Eacility
Rapp Funeral and Cremation Services 21. Signature of Funeral Service Lice 1400382 Gist Ave., Silver Spring, MD 20910 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part 1, Enter Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician respirator tailure disease or condition Medical resulting in death) Examiner hronic ulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-transit tibrilla tion To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-trains. Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be an above after death tension Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 A No Month Day 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown poxIa 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Yes 2 No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one) 29b. Signature and title of certifier MAR 41162 December 30,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doctors Drive, Germantown, Manylond Ganti MD 19529 Vinu 20874 31. Date filed (Month, Day, Year) State JAN04 2013 Registrar

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2012

December 29,

				Please	Type or Pri	nt in Blac	k Indelible In	k. Ensure A	II Copies	Are Legib	e.
				For	State of M	aryland / D	epartment of I	Health and M	lental Hygi	ene	
				State Registrar			Certificate of I	Death	Re	g. No. 20	2 42800
		Physicia Medic		1. Decedent's Name (First, Middle, Las	etter				2. Date of Death Month	Day 31 ZO	3. Time of Death
		Examir		4a. Facility Name (if not institution, give	street and number)	Hospit	4b. City, Town, o	Location of Death		4c. County of E	
		Funeral Director		5. Social Seturity Number 6. Se	7. Ag	e (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	Year) 9.	Birthplace (State or Foreign Country)
			_	Usual Residence of Decedent 10a. State 10b. County	M Z LI F	10c. City, Town	rs.		Dec. 3,	1934	10d. Inside City Limits
	Manylan	28e-fst	Director	MD Ceci	l		excyville	2			1 Yes 2 □ No
	Andrew Attention	23a or 3		10e. Street and Number	Ctro	++1	10 Zip Code	903	10	Og. Citizen of What	Country?
	#	ems L	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. Was Decedent of H	lispanic Origin? (Spe	cify Yes or No-	14. Race - A	merican Indian,
6		0,1	è	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏞 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No	If Yes, specify Cuba 1 ☐ Yes 2 🗷 No	Specify:	Rican, etc.)	Black, W Specify:	Mite, etc. Black
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9	Mary Sepondo	h and Mental 7 Is marked c		19a. Informant's Name/Relationship (Ty	1 1	1 11 1 /	Mailing Address (Street			0	14 71070
F	e, e	item 2		20a. Method of Disposition	own dalla	20b. Place of	Disposition (Name of		Ne de	O race 1	or Town, State
	baltimore,	tment c tant: If		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	y)	Garris	on Frest G	em. Jan.	11,2013[wings.	Mills, MD
	Call	Depar Impor eny in		21. Signature of Funeral Service Licens	Diff. MI	01443	22. Name and Addre	ss of Facility	4 Steph	Bolto.	MO 21286
012				23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	plications that caused ne cause on each line	d the death. Do no	ot enter the mode of dyin	ig, such as cardiac o	r respiratory arres	t,	Approximate Interval Between
7	PT	ysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. So F	otic	Shoc	k_			Onset and Death
3	Ε	xaminer	L.	Sequentially list conditions,	Pa	eur	ONIA				4 days
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	t the deat	y the at ached fo	Physician/Medical	1 Yes 2 No 9 Unknown	4 Pregnant a	t time of death	5 Other (specify)			Month	Day Year
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0)	THE LAW REQUIRE	s been s	Completed by						24a. Was an	24b. Were	autopsy findings available
	The la	cate ha							autopsy perform 1 🗌 Yes 2	prior deatl	to completion of cause of n? Yes 2 \(\square\) No
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5	OI VICAL a Physician:	er this	te: To	27. Manner of Death	28a. Date of inju (Month, Day	rv 28b. Ti	me of 28c, Injur	4 ∐ Nursing Ho yat	me 5 LJ Residen 28d. Describe how	ce 6 Other (S)	pecify)
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off	DIVISION itel or Attendi	irs after rel Direc lled in by		4 Homicide determined	building, etc	c. (Specify)	n, street, factory, office		City or Town,	State)	Rural Route Number,
(de Hosp	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the	Medical	(Check 2 L Medical Examin	ner: On the basis of e	xamination and/or	eath occurred at the time investigation, in my opinion ledge, death occurred at the	on, death occurred at	the time, date and	place, and due to t	he cause(s) and manner stated.
_	To #	Vith com		29b. Signature and title of certifier	2 OM		29c. Licens	e number	29	d. Date signed (Mo	onth, Day, Year)
		X		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (T	/pe, Print)			200100	1,2012
		•		Jeffrey Thomp	son, MO	500 U	pe, Print) Poer Chesar	peake Dr.	Bel au	ir, md.	21014
		Stat Registra		on Date JANOUT, 48,2013	Levis Begisty	Sign Control					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Carl N. Patrick Jr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8. Date of Birth (Month, Day, Year) Aug. 4, 1934 Funeral 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 219-32-4219 Days Hours Director 78 1 ₹ M 2 🗀 F or then "neturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Essex 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 92 Ginwood Lane 21221 USA Was Decedent Ever in U.S. Armed Forces?

1 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pege 1 and 2 should be filed within 72 Department of Heelth end Mentai Hyglene. Importent: If Item 27 is merked other then 'eny Injury or other treumetic event, Item 6 College (1-4 or 5+) Elementary/Secondary (0-12) Analyst Beth Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carl N. Patrick Sr. Lillian Jones 19a. Informant's Name/Relationship (Type, Print) . Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Ginwood Lane Baltimore MD 21221 Elizabeth Patrick /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State HoIIy Hill Cemetery 1/3/13 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugline Service Lie 22. Name and Address of Facility 300 Mace Ave. Balto. Home of Essex 21221 Connelly Funeral 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Priysician/ Medical resulting in death) Due to (or as a consequence of): [']Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due the (or as a consequence of): Examin ettending physicien end I for use es the buriei-transit Hospitel or Attending Physicien: The lew requires that the deeth certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Dav 24 hours efter deeth.

Funerel Director: After this certificate has been signed by the eletey filled in by the funeral director, page 2 should be detached f g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature and title of certifier Name and address of person who completed car use of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42803 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 28 Physician/ Month Bertie Ella Pettit 5:15 A. 2012 Medical December 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Charlestown Nursing Home Catonsville Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 220 26 4354 1 □ M 2 🗶 F Yrs. 05/01/1928 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Baltimore Maryland | Catonsville 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 715 Maiden Choice Lane Apt. CC217 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Completed by 1 X Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Health and Mental Hygiene. tem 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Truck Leasing Administrative Assistant Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Noel Edward Pettit Mildred H. Buckner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita Gutschick / Niece 1171 Cavalier Road Arnold, Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 cemetery, crematory or other place) 01/03/2013 Suitland, Maryland Washington National 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ theroscleron c Cardiovas culer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of, If any, leading to immedicause. Enter Underlying Exami ending physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal deat Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Hyperters or 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 20 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific. Division of Vital funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) M Butterworth R082382 12-31-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CENZ 709 Maidenchoice Care Ballo Md 21228 Ann Be Herworth

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year,

JAN 0 4 2013

32. Registrar's Signature

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-	Examin		Stella Ma	aris					Tir	noniu				E	Balti	more	Count	
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8:56 a.m. 21215-0036	permit. Page 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaminer must be recifited at once.	þ	1 Never Marri	21	ied 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	d Forces? Yes 2 ☐ , Give or Dates.	No		If Yes, spe	cify Cuba	ın, Mexica	n, Puerto I	Rican, etc.)			k, White,	etc.	
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DAVID P.O. B	that th ned by e detac	by Ph	Part II. Other signifi	icant condition	ns contributing	to death b	out not res	ulting in the	underlying	cause giv	ven in Part	l.	23e. Did t	obacco	use contri	ibute to t	the cause of d	eath?
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Division	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	al Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determin	28e. P	lace of Inju		me, farm, st)	reet, factor	y, office		1	28f. Location (City or Tov			r or Rura	l Route Numb	oer,
	ne Hospi in 24 hou e Funer pleteiy fil	Medical	(Check 2	Certifying Medical Ex	caminer: On the	e basis of e	xamination	and/or inve	stigation, in	my opinio	n, death o	ccurred at	the time, date a	and plac	e, and due	to the ca	ause(s) and ma	nner stated.
	To the within com		29b. Signature and t	title of certifier	enci	1 NH	1	-	29	c. License	number 44	197		29d. D	ate signed	Month,	Day, Year)	
	141		30. Name and address	I.	no completed			, , , , ,	,	/ 		, _			1-1	0-1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ MOS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct. 14 Social Security Number 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign **Funeral** ^{Year)} 1930 Days Director 212-28-6217 Oct. 1 X M 2 🗆 F 82 Usual Residence of Decedent . Page 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hygiene. Sant; If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director Pasadena 1 🗌 Yes 2 💢 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 783 Woods Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 2 🗌 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Box Manufacturing Pressman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Catherine Wilheim Ruby Paris Lawton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 783 Woods Road, Pasadena, MD 21122 (daughter) Phyllis Basil permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Qonation 5 Query (Sec. 14) Jan. Date 03 20c. Location - City or Town, State Baltimore, MAryland Loudon Park Cemetery 2013 21. Sign 22. Name and Address of Facility of Funeral Service License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the dis sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and beath ease, or comp shock, or heart failure. List only of Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate beafter death.

Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 2 No be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ပ ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of the best of the same with the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 21438

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Decedent's Name	(First, Midd	le, Last)									2. Date of De Month			3	3. Time of	Death
	Physicia Medic		Anna H. Ros	enblum										12	26	2012	1	0:05	д М
-	Examin		la. Facility Name (if i	not institutio	n, give s							Location of	of Death			c. County of Dea ontoomery			
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	Funeral Director		5. Social Security Nu 215–42–3557	,	6. Sex] м 2 Х) F		111 yrs. 14s 04	Yrs.	Months		Hours	Min.	(Month, Da 4-1-190	y, Year)	C	ylan		
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	eath v tams er mu	E	11. Marital Status			12, Was Dece		er in U.S.	13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi			
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Maryland 21215-0036	12 should alth and N 27 is ma r trauma		19a. Informant's Na Stuart Gar						19b. Maili 46 11	ng Addres Davids	s <i>(Street a</i>	and Numb ive, C	er <i>or Rur</i> a hevy l	d <i>Route Numb</i> Chase, Ma	er, City o aryla	or Town, State, 2 and 208 1 5	Zip Coa	ie)	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Meckeal Exeminer must be notified at once.		20a. Method of Disp 1 X Burial 2 4 Donation	☐ Crematio			State	ce	ace of Dispo metery, crea	matory or	other plac			Date D-2012		Location - City o			a
Balti	permit. EDepartments Importations and injured		21. Signature of Fu	heyal Service	∔ icense	e Len	ard K	(ent	2	2. Name a	nd Addres	ss of Facili	ty Edw e, Ro	ard Sage. ckville,	l Fur Mary	neral Dire /land 2085	ection 52	on	
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_	icata be executed physician and is the burial-transit	edical Examiner	that initiated event resulting in death)	s Last	ι	C. Due to	(or as a	conseque	ence of):				_						
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Ö	es that the dea signad by the a i be detached f	y Ph	Part II. Other signif	ficant cond	itions co	ontributing to	death bu	ut not resu	llting in the	underlying	cause gi	ven in Par	t I.	23e. Did	tobacc	use contribute	to the	cause of c	leath?
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ecord	a law require has been signed 2 should I	Completed												per	opsy formed	death	o comp	pletion of o	available ause of
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/ita	ysicia is cert direct	To Be	examiner? 1 🗌 Yes 2 l		1.	Hospital: 1 □	Inpatie	ent 2 🗆 1	ER/Outpation	ent 3 🗆 I	DOA Oth	er: 4 🗆 N	lursing H	ome 5 TRes	sidence	6 ☐ Other (Sp	ecify)		
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Division of Vital Records, P.O.	or Attend after death Director: /	Certificate:	3 Suicide 4 Homicide	6 🗌 Cou		e 28e. Plac		ry - At hoi . (Specify)	me, farm, si	reet, facto	ry, office	-		28f. Location City or To		and Number or i	Rural R	loute Num	ber,
Δ	To tha Hospital or Att within 24 hours after d To tha Funeral Direct complately filled in by 3	Medical	(Check	2 Sending	I Evami	nor On the h	eie of ex	ramination	and/or inve	stigation i	n my onini	ion, death (occurred a	at the time, date	e and bla) and manner as ice, and due to thuse(s) and manne	ne caus	e(s) and ma	anner stated
	o tha	Σ	only one) 3 29b. Signature and			se Practitione	er: 10 the	e best of it	ny knowledg			e number	ate and p	iace, and due to		Date signed (Mo			-
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Physician/ Mark Rubin Day 30 Yea 2012 AM 8:32 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 17518 Gallagher Way Diney 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min (Month, Day, Year) Director 213-42-5708 1 X M 2 □ F Il 10-18-1941 Usual Residence of Deceden 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours efter death with the Merylend rel", or iteme 23e or 28a-f sho Examiner must be notified at Director MD Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20832 17518 Gallagher Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. à 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 X Divorced White Completed Year or Dates. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mantai Hygiane. is merked other then Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Management Housing æ peli 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Doris Miller Abraham Rubin Paga 1 end 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 is 11344 Amberlea Farm Drive, N. Potomac, Maryland 20878 Jeffrey Rubin - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State þ King David Mem. Gardens Falls Church, Virginia 1-2-2013 4 ☐ Donation 5 ☐ Other (Specify) Ma Price D 21. Sign Lenard Kent 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attanding Physician: The lew requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificata has been signed by the attending physicien and compietely filled in by the funeral director, page 2 should be detached for usa as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month. Day, Year) 248 2013 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) JAN Q 4 2013

David Plotkin, MD - 18111 Prince Philip Drive, #304, Olney, Maryland 20832

32. Registre 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical Maraaret 2012 December 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 DM 2 S 216-36-8305 74 Director July 31,1938 Maryland Usual Residence of Decedent with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Dunda1k 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō Items 23a Funeral 1643 Gray Haven Court 21222 United States Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2X If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) other than College (1-4 or 5+) 3 Years Housewife Own_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event, one. Be Francis E. Campbell Margaret O. Harris မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edward R. Ruckle(Husband) 1643 Gray Haven Court Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 1/3/2013 Towson, Maryland 21. Sign ture of Funeral Service License Dennis 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Carroll 7922 Wise Ave. Dundalk, Ma Do not enter the mode of dying, such as cardiac or respiratory arrest, Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner rdiomyopathi schemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i 23e. Did tobacco use contribute to the cause of death? þ ordnang 2 No 3 Probably 4 Unknown 1 T Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗌 No 1 Tes certificate 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural After 5 Pending investigation after death.

Director: Af
d in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 4 Thomicide City or Town, State) in 24 hours the Funeral Directory filled in the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year)

JAN 0 4 2013 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 02:50AM 2012 December /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Hours Days M 2 □ F 187-12-2956 09/18/1922 **Director** Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show Examiner must be notified at 1X Yes 2 □ No Director PA 28a-f York Dallastown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ö 719 Summit Drive 17313 **USA** Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

Y☐ Yes 2 ☐ No Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0036 ö Yes. Give 1 ☐ Yes 2√☐ No Specify: þ Specify 3√ Widowed 4 Divorced Year or Dates: 'natural", White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Federal Government than, Elementary/Secondary (0-12) College (1-4 or 5+) 12 Serviceman and Mental Hygie is marked other Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, tonce. 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be ည Edward B. Rothrock Alice Mae Maines 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Rothrock / Son 2719 Cotoneaster Court, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 1/1/2013 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Swetch. Marshall Dorota Marshall 1 Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CENTRICATION APPRIATED BY MEDICAL 25 **Physician** NTRACEREBRAL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 TYes or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 1

Yes 2 □ No 1 X Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1
Natural Injury 5 Pending 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Residence 1 Tyes investigation 2 Accident 3 ☐ Suicide Stairs at Home 11 CLOWN 6 Could not be 28f. Location (Street and Nymbe City or Town, State) 50/3 tle Cone determined 4 🗌 Homicide 24 hours a Funeral L the Hospital 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 38661 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001 11595

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g936 2-19-13 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201Z Month 3:25 AM Catherine May Roche Catherine Mary Roche Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST HONES HOSAITAL BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.
May 29, 1925 5. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2 😾 F Country) Maryland Director 213-20-5107 87 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Halethorpe 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5719 Second Ave. 21227 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 X Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) transportation bus driver 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mary Gwendolyn Ulrich Charles Emmet Doudiken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5709 Second Ave; Baltimore, MD 21227 Susan Roche - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of F meral Services licental On a 1 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIFF COLITIS Pnysician/ disease or condition ੂ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE cate has been signed by the attendin page 2 should be detached for use 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Dav Year 9 Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown MAIAL PIBBILLATION 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pendina 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
AC 27 20 MD 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN PHENUS GOV S CATTO AV 2 BALTIMORE mA 21220 AVE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

OF THE RICH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7. Age (In yrs. ast birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 220-18-9565 Director 1 □ M 2 X F NOV 16 MY/AND 2 should be filed within 72 hours after death with the Meryjend that and Mental Hyglene. 27 is marked other than "neturel", or items 23s or 28s-f ehow treumetic event, the Medical Estimine must be motified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MORC 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. Never Married 2 Married δ 1 ☐ Yes 2 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DISABLED 2 DISABLED B 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kavenscroft 1 end 2 should b of Heelth and Mei item 27 is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Broth injury or other Baltimore, Important: If iten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service Licensee 22. Name and Address of Facility 21224 23a. Part 1. Externh di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac er respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (F al disease or con fit resulting in death) Physician no metricia Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of): the Hospitel or Attending Physicien: The lew requires that the death certificate be executed ettending physicien and for use es the buriei-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day been signed by the s should be deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificete hes b erei director, page 2 s autopsy 1 ☐ Yes 2 ☐ No 2 \ No Division of Vital 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No å 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funerei 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending iniury work?
1 Yes 2 No s efter death.
I Director: Aft
id in by the fur ☐ Accident ☐ Suicide Investigation within 24 hours efter dea To the Funerel Director completely filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hind an 500-

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State Registrar 31. Date filed (Month, Day, Year)

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			For State Registrar		e or Mai	ryland / De _l Ce		ent of F		and N	tental Hy	gien Reg. M	71)12	4	2812
	Physicia Medic		1. Decedent's Name (First, Midd Richard	le, Last)		Sha					2. Date of De Month Decem		^{Day} 31,	2012		e of Death 11 A ^M
<u>.</u> ≯ ∞.	Examin	er	4a. Facility Name (if not institution		number)		4b. Ci	ty, Town, or				4	c. County			
Same of	Funeral		Suburban Hosp 5. Social Security Number	T6. Sex	7. Age (In yrs. last birthday) If Un	Be to der 1 Year	hesda I If Under		8. Date of Bi	rth	MO	ntgom		te or Foreign
	Director		132-32-2155	1 🛛 M 2 🗆		78 yrs.	Month		Hours	Min.	Jan.	ay, Year,		Count	ry)	ic or r oreign
	how #	'n	Usual Residence of Decedent 10a. State 10b. Count	y	1	IOc. City, Town or I	ocation							11	Od. Inside	e City Limits
	Aaryla Be-f s	rect	MD Mc	ntgomery	.	F	lockv	ille							1 🗆	Yes 2 No
	e or 2	Funeral Director	10e. Street and Number				10f.	Zip Code				10g. (Citizen of	What Coun	try?	
	th witi	ner	10148 Sterlin						850				nite	d Sta	tes	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	þ	Narital Status Never Married 2 ☑ Ma Widowed 4 □ Divorce	Armed	Decedent Event of Forces? Nes 2 \(\overline{N}\) No Give or Dates.		If Yes, sp	cedent of Hoseify Cuba	in, Mexica	n, Puerto	cify Yes or No Rican, etc.)	-		ce - America ck, White, e		
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Maryland	d 2 should elth end M i 27 is ma ir traumai		19a. Informant's Name/Relation Marjorie Sha /				-				Route Numb		-		ode) 2085	0
Baltimore,	of He		20a. Method of Disposition 1XXXBurial 2 ☐ Cremation	а П пI	Ctt-	20b. Place of Dis	oosition (N	lame of	ye)	(Date	20c.	Location	- City or To	wn, State	,
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Bal	permit Depar Impor any in		21. Signature of Funeral Service	Licensee	Moo	382	Rapp 933	and Addres Fune Gist	ss of Facili ral a Ave.,	and C	rematio	on S	ervi	ces 20	910	
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	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	YPOTE										Onset a	nd Death
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Box 68760	Hospital or Attending Physicien: The law requires that the death certificate by 24 hours after death. Funeral Director: After this certificate has been signed by the ettending physicately filled in by the funeral director, page 2 should be detached for use as the backy filled in by the funeral director, page 2 should be detached for use as the backy filled in by the funeral director.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 L 4 F	outcome of ive Birth 2 Pregnant at ti Inknown	Fetal death 3	☐ Ectop	ic pregnand (specify)	гу					ate of delive	ry Day	Year
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Division of Vital Records,	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the	al Cert	4 ☐ Homicide deter	mined 28e. Pl	uilding, etc. (28f. Location (City or To	wn, Sta	te)			imber,
	Host 24 ho Fune etely f	Medical	(Check 2 L Medical	Examiner: On the	basis of exam	y knowledge, deatl mination and/or inve	estigation,	in my opinio	on, death o	ccurred at	the time, date	and plac	ce, and du	e to the cau	se(s) and	manner stated.
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	Q		30. Name and address of persor	wwo completed o	ause of dea	th (Item 23a) (Type	Print)									
_	V		KIMBERLY ZUZAK			OLD GEORG	GETOW	N RD.	, BET	THESD	A, MD	20)814			
	Stat Registra		31. Date filed (Month, Day, Year)	2013	Registrar's	Signature	alle	/								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day}9, DECEMBER IRENE STANCILL 2012 MAE 4: 07 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FOREST HILL HARFORD FOREST HILL HEALTH \$ REHABILITATION Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Months Hours Min. (Month, Day, Year) 213-28-8663 **Director** 1 □ M 2 🗓 F Usual Residence of Decedent 80 22, Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2344 Pennington Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Payroll Clerk U.S. Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth eny injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Brady Eugene Caudill Mamie (nmn) Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Stancill / Daughter 2344 Pennington Road, Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Remo 4 Donation # Other (Specify) Air Memorial Gdn. 1-4-13 Bel Air, Maryland Sking ture of Fu al Sef 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Due to (or as a consequence of): ∕Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 출| Completed been sig 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 06-2011

Registrar

State

Down 5

31. Date filed (Month, Day, Year)

JAN 0 4 2013

DR. DAVID DUNN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615. W. MACPHAIL

32. Registrar's Signature

D3 2275

AIR,

BEL

ROAD

29d. Date signed (Month, Day, Year)

MD. 21014

Decimber 31,2HZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Shaw 947 2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Par Adventist Tentgomery Hospita Takoma If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Months Hours (Month, Day, Year) **Director** 86 1 M 2 TF Ternesse 3/11/1926 Usual Residence of Decedent or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho eny injury or other treumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD Prince Georges Lanham 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5724 Hiland Ave. 20706 USA 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

NUTSE Elementary/Secondary (0-12) College (1-4 or 5+) Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Unknown Mary Stowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Shaw-Bracey (Daughter) 5724 Hiland Ave. Lanham MD 20706 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pladensburg Maryland 1 K Burial 2 Cremation 3 Removal from State Fort Lincoln Cenetery 4 Dogation 5 Other (Specify) DC 20011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. & Jenkins Funeral Home 716 Kernedy St. NW Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition ardiovascular Medical resulting in death) Due to (or as a consequence of) Examiner ypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (*r as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed perlipidenie Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Ectopic pregnancy Month 5 Other (specify) Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 X No Yes 2 No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director Afte completely filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 ☐ Could not be 3
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lakema 31. Date filed (Month, Day, Year) 32: Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month dV14 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL ROSEDALE BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 9. Birthplace (State or Foreign 218-14-2293 89 Director 1 □ M 2 🔀 F MARYLAND JULY 6,1923 Yrs 27 is mar led other than "natural", or items 23a or 28a-f shov traumati event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PARKVILLE MD. BALTO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 8810 WALTHER BLVD. #3217 within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ۾ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) HOME HOMEMAKER 12TH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ AMANDA WILSON HENRY BARTLING permit. Page 1 and 2 should Department of Health and Me Important: If item 27 is mari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON LOUIS J. SLIFKER 11119 OLD CARRIAGE ROAD GLEN ARM, MD. 21057 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State SACRED HEART OF JESUS 1-2-2013 DUNDALK, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part 1. Entir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a con quence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examir Cause (Disease or injury igned by the attending physician and be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
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Director: After this certificate has autopsy performed' 1 Tes 2 1 No the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(\text{Amb} \) \(\text{eq.} \) ည 1 Yes 2-1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 28. Beyla M. Solntseva 3:15 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - F Hours Jamonth 9^{ay,} **1919** U.S.S.R. **Director** 93 218-43-8248 Usual Residence of Deceden "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 95 Dawson Avenue #201 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. College (1-4 or 5+) **5** Elementary/Seconday (0-12) the Chemist U.S.S.R. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental + 27 is marked or traumatic eve Moisha Karlin (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Vladimir Sonsev/son 42885 Waxpool Road Ashburn, VA 20148 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔲 Burial 2 🔀 Cremation 3 🗌 Removal from State Final Journey Crematory 01/02/13 4 Donation 5 Other (Specify) Woodbine, MD 21. Signatura of Funeral Service Ligenses Going Home CRemation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death -Physician/ disease or condition resulting in death) a. Dementia Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if in leading leading cause. Enter Underlying Examine Due to for as a nonsequence of Cause (Disease or linjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🔀 No Month Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been a 24a. Was an 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director, After this certificate has autopsy perform 1 Yes 2 No Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No 일 1 Inpatient 2 ER/Outpatient 3 IDOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ture munn 1-2-13 D006487 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Mina Fazli, MD

JAN 0 4 2013

31. Date filed (Month, Day, Year)

6121

32. Registrar's Signature

Montrose Rd. Rockville, MD 20852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Marguerite Sponaugle Dec 2012 A M Medical 6:38 Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Parkville Quail Run Assisted Living Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Director Hours (Month, Day, Year) 1 □ M 2 😾 F 217-28-9798 80 Yrs. Dec. 9, 1932 Maryland or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a, State 10b, County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Joppa 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3008 Woods End Drive 21085 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Verizon 12 Years Customer Service permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lottie Bishop Chester Benson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol P. Edmond (Daughter) Joppa, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gdns. 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/3/2013 Middle River, Maryland 21. Signature of Funeral Service Licensee Reed 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner RTBN SID Securifically list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease) that initiated events Examine signed by the attending physician and Id be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? cate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 ☐ Yes 21 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Assiste 2 🗘 No Certificate: To 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Director 3 Suicide 6 Could not be Š Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or

To the Funeral Direct
completely filled in by 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 [V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12-31-12 State Registrar

12-09900 Lindsay Smith Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

inusay Simin	1-For State Certificate of Death Registrar Reg. No. 2012	281
Physician/ Medical Examiner		of Death 9 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
Funeral	St. Agnes Hospital St. Agnes Hospital Baltimore N/A 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Security Number)	State or
Director	Foreign	ryland
d ow any	10a. State 10b. County 10c. City, Town or Location 10d. Ins Maryland Baltimore Halethorpe 1	ide City Limits
h the Maryland 13a or 28a-f sho totified at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Washington Avenue 21227 U.S.A.	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once ed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American India White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Yes 2 X No	n, Black,
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1215-0036 de filed within 72 hour fental Hygiene. rerked other than "naturevent, the Medical Exam Dee Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 10th College (1-4 or 5+) Hostess I Hop Restau:	rant
be fill	Edward K. Smith, Sr. Cynthia L. Rooney	
	19a. Informant's Name/Relationship (Type, Print) Cynthia Smith / Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 605 Washington Avenue Halethorpe, Maryland	
2 a a 2 1	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20c. Location - City or Town, State 20c. Removal from State 20c. Removal from State 20c. Location - City or Town, State 20c. Removal from State	ate
Baltimore, permit. Pages 1 at Department of Hee Important: If ite injury or other tr	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, F	·.A.
Physician		nd 21225 timate Interval en Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Narcotic (free morphine) Intoxication Due to (or as a consequence of):	Death
iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	<u> </u>
outed nd transit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
60, ate be executed hysician and te burial - transit	▼ UNPENDED ▼ AMENDED 23a, 27, 28a - f. per me, g937 3-29-13 sm #28f, per me, g938 4-8-13 sm	
k 687 n certific ending p use as th	FFEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1	Year
D.O. Boy that the deatl ned by the att detached for by Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	of death?
ires that signed libe deta	1 Yes 2 No 3 Probably 4	Unknown
Records, The law requires ficate has been signage 2 should be Completed	24a. Was an autopsy find prior to completion death? 1 ✓ Yes 2 No 1 ✓ Yes	ings available of cause of
Vital Reconsiders: The his certificate director, page	25. Was case referred to medical 26. Place of Death (Check only one)	2
f Vit Physic er this c ral dire	1 Ves 2 No lossified 1 Inpatient 2 ER/Outpatient 3 DOA Outer 4 Nursing Home 5 Residence 6 Other:	
	1 Natural 5 Pending fd 12-27-12 fd 00:40 am 1 Yes 2 No 1 Yes 2	
2 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Accident Investigation Accident Investigation Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route or Town, State)605 Washington 4 Homicide 4 Homicide 4 State 4 State 4 State 4 State 5 Sta	Number, City
)
To the Howitin 24 To the Free completed		
10 pent	30. Name and address of person who completed cause of death (Item 23a)	
1 1	Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	1	

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1:00 PM Sorvalis December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bullin Baltimore Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗔 🗸 Months Hours Min Month, Day Director 292-44-0518 98 Greece Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pines. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9301 Flagstone Drive 21234 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paradise Christodoulos Rigas Kaliopi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pete Sorvalis-son 9310 Flagstone Dr., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 1/3/13 Demetrios Baltimore, MD Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Intracrania Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an cate has bage 2 s autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🖪 No 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Ecertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie RU86520 31 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Ethidje, Md.

Registrar DHMH 17 Rev 7/2009

State

Marsholde

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32. Registrar's Signatu

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31. Date filed (Month, Day, Year

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David Johnathan			St	ate of Marylar						Ment	al Hyg	giene				
		1- For State Registrar				Certifi	cate of	Death					Reg. N	lo 2	01	2 1.20
Physicia		Decedent's Nan	ne (First, Midd	le,Last)		-					2	. Date of De	eath		-	3. Time of Death
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Many 1			(if not institution	on, give street and num	ber)	-		b. City, To	wn, or Lo	ocation of				4c. County of	of Death	
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Funeral		5. Social Security	Number	6. Sex 7	. Age (In y	re last h	irthday)	If Under	1 Vear	If Under	24Hrs	8 Date of	Ridh (84		•	hplace (State or
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withii ene.	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busing the properties of the properties									TUDE	UDENT					
5-C		17. Father's Name	(First, Middle,	Last)					18	.Mother's	Name (F	irst, Middle	, Maide	en Surname)		
be fi	å	BRUCE					CHERR			KAND.					IPS	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "matural", or items 33a or 28a-f shou injury or other traumatic event, the Medical Examiner must be notified at once.	P	19a. Informant's Na	ame/Relations	hip (Type, Print)		1	9b. Mailing	Address	(Street a	and Numb	er or Rur	al Route N	umber,	City or Town	, State,	Zip Code)
MC 12 st 12 st 127 uma	1	KANDACE SCHERR/MOTHER 801 KEY HIGHWAY, #234, BALTIMORE, MD										21230				
e, and Heal item	- [20a. Method of Dis			Ob. Place	b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To									Town, State	
TOT ages of the of the	1 X Burial 2 Cremation 3 Removal from State ARLINGTON CEMETERY—										T 1/D					
ti. P. rtmer	4 Donation 5 Other Specify: CHIZUK AMUNO CONG. 12/30/2012 BA 21 Signature of Funer Service Ucensee 22 Name and Address of Facility SOL LEVINSON &										BALTI	MOR	E, MD			
Baltimore, permit. Pages 1 an Department of Heal Important: It iten	- 1	ALA/IA	and b	111 400												
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760 icate phy the b	Š[IF FEMALE: 3b. Was decedent	pregnant in th	23c. If yes, out		regnancy				1			2	3d. Date of		
68 Sertif	Ē	past 12 months		e 1 Live birtl 4 Pregnan		f death		al death		Ectopic p	pregnanc	у	- 1	Month	D	ay Year
Box 68760, e death certificate be the attending physic defor use as the burner defor	Sic	1 Yes 2 1	No 9 Unk	nown 9 Unknow		, ucalli	5 Oth	er (Specify)				1			
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Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.

To the Funeral Director: A completely filled in by the fur

Completed

Be

Certification:

Medical

After this certificate has been sfuncted director, page 2 should

1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Pending 1 Yes 2 X No subject asphyxiated

fd 12-28-12 |fd 10:16 pm 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide Could not be found in car (Specify) Homicide 29a. Certifier 1 [

28f. Location (Street and Number or Rural Route Number, City or Town, State 01d Rt. 450 and Rt 197 Bowie, MD.

December 29, 2012

10d. Inside City Limits 1 X Yes 2 No

Approximate Interval Between Onset and Death

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State 31 Date filed (Month, Day, Year) Registrar

JANO 4

ORIGINAL

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eney Basell Ta	nne	1- For State	State o	of Maryl	and / De	epartm Certific				Ment	al Hy		2	01:	2 4282
Physicia	an/	1. Decedent's Name (First, N	iddle,Last)		`						2	2. Date of Dea	ath		3. Time of Death
ledical Exami	ner	ATTITLE D. TO	nner Ji									Month Novembe	r 24, 2012	ear	0305 hrs
		4a. Facility Name (if not insti Upper Chesapeake	-		umber)		4	b. City, To Bel Air	wn, or L	ocation of	Death		4c. County Harford		n
Funeral	Ġ	5. Social Security Number	6. Sex		7. Age (In y	rs. last bir	thday)	If Under	1 Year Days	If Under	24Hrs. Min.	1	irth (MM/DD/YY)	Y) 9. Bii Forei	thplace (State or
Director		213-98-3203		v1 2 F		31	Yrs.	WOTHIS	Days	Hours	IVIII I.	5-25-1	.981		puntry) MD
any		Usual Residence of Deceder 10a. State 10b. Cou			10c.	City, Town	or Location	on							10d. Inside City Limits
	ō	MD	Harford	1		Abii	ngdon								1 Yes 2 No
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked tuber thao "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1214 Coyote Co	ırt			-		10f. Zip C	ode 1009		-		10g. Citizen of V	Vhat Cou ISA	ntry?
leath with r items 23	Funeral	11. Marital Status 1 X Never Married 2	_	12. Was De Armed F	cedent Ever			Decedent s, specify				cify Yes or No tican, etc.)	Wh	ite, etc.	ican Indian, Black,
after c	by F	3 Widowed 4		f Yes, Give Ye or Dates:	ar			Yes 2	<u></u>						an-American
2 hours		 Decedent's Education (Elementary/Secondary (0- 			de complete 1-4 or 5+)			s Usual Od st of worki					16b. Kind of E	Business/	Industry
215-0036 be filed within 72 hours s ntal Hygiene. rked nther thao "natura ent, the Medical Exami	Completed	11th				S	ales						Car De		ship
ID 21215-003 should be filed within and Mental Hygiene. T is marked other the natic event, the Med	Be Co	17. Father's Name (First, Mic							18			First, Middle, • Miller	Maiden Surnam	e)	
21) hould then of Men is mar	2	19a. Informant's Name/Relat	onship (Typ			7.5				and Numb	er or Ru	ral Route Nu	mber, City or To	wn, State	, Zip Code)
e, MD I and 2 sho Health and item 27 is	1	Kathryn A. Tann 20a. Method of Disposition	er Eato	on/ Moti		0b. Place	of Disposit	ion (Name	Ct.,	Abing tery,		MD 2100 Date)9 20c. Location	- City or	Town, State
MOFE Pages 1 ient of H int: If i	Į	1 Burial 2 X Crema 4 Donation (5 Othe		Removal f	rom State	etro (cremet	er place) OLY		1	1-29	-2012	Baltim	ore, N	1D
Baltimore, permit. Pages I an Department of Hea Important: If itel injury or other tr		21. Signature of Funeral Ser	ide License	1							_				Balto. Co.
Physician	\dashv	23a. Part I. Enter the disease			caused the de	eath. Do no							n, MD 2113 rest, shock, or h		Approximate Interval
/Medical Examiner		failure. List only one ca Immediate Cause (Final dise or condition resulting in deat	ase a. M	ultiple Inj			_								Between Onset and Death
1		Sequentially list conditions,	у Di b	ue to (or as a	a consequen	ce of):									:
	nine	if any, leading to immediate cause. Enter Underlying Ca (Disease or injury that initiate	ise	ue to (or as a	a consequen	ce of):									
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(ecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - transi		IF FEMALE: 23b, Was decedent pregnant	n the	23c. If yes,	outcome of p		☐ Fets	al death	3	Ectopic p	pregnant	÷v.	23d. Date of		/ Day Year
ox 61 eath cert attendir	sicia	past 12 months?	Unknown	4 Pregr	nant at time o	of death		er (Specif)			-5				,
D. B. t the de by the		Part II. Other significant con		9 Unkn	own o death but n	ot resulting	g in the un	derlying ca	ause giv	en in Part	l.	23e. Did to	obacco use con	ribute to	the cause of death?
ires that th signed by I be detach	d b				. = .						_	1 Ye	s 2 No 3	Prot	oably 4 🗸 Unknown
ords, w requir as been s	Completed											24a. Was autor	osy	prior to d	topsy findings available completion of cause of
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Vital hysician:	Be	25. Was case referred to med examiner? 1 ✓ Yes 2 No		spital: 1	Inpatient 2	✓ ER/O	utpatient		Io	Death (C			Residence 6	Other	
Sing Phy	n: To	27. Manner of Death		28a, Date	of Injury n. Day Year) 2012	i	Time of Inj	ury 280		at Work?	ls.		how injury occur		involved in motor
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been is led in by the funeral director, page 2 should	catio		ending vestigation		e of Injury - A) hrs	factory		s 2 V N	IO VE	ehicle acci	dent		ral Route Number, City
Division of Vital Hospital or Attending Physician: 24 hours after death. Ruoeral Director: After this certif	Certification:		ould not be etermined		Major R			, lactory, o	ince buil	iding, etc.	- 1.	or Town, S			
Division To the Hospital or Attendit within 24 hours after death. To the Fluorial Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifying one) 2 Medical	xaminer:0		of examination								se(s) and manne and place, and		
E 3 E 8	ŝ	29b. Signature and title of ce		a i	stateu.				icense r		OOME.	-			nth, Day, Year)
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フリ		 Name and address of per Theodore M. King, 					iner 9	00 W. B	altimo	re Stre	et, Bal	timore, MI	D 21223		
Sta Regist		31. Date filed (Month, Day, Ye	ar)	32. R	egistrar's Sig			,							
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month DELORIS TABRON 8145 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOSEPH RICHEV HOSPICE BALTIMORE 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 213.32.21068 Director 1 M 2 VF 18 MD 27 1934 10a. State 10b. County or then "neturel", or Items 23e or 28e-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo MD BALTIMORE 1 ☐Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral WINGTON AVENUE 21239 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced Specify: BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY College (1-4 or 5+) Elementary/Secondary (0-12) TEACHER PUBLIC SCHOOL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Heelth and Should be Department of Heelth and Mente Importent if item 27 is marked eny Injury or other traumethe 2000s. မ LAWRENICE MILLS LUCILLE SINGLETARY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD TABRON, HUSBAND 1353 WINGTON AVENUE BALTO, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pl 20c. Location - City or Town, State Date 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State ARBUIUS CEMETERY 4/2013 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
VAVGHN C. GREENE FUNIERAL SVCS.
4905 YORK RD. BALTO, MD 21212 8 M1634 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner equentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami signed by the ettending physicien end d be detached for use es the buriel-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> Records, Completed 3 Probably 4 Unknown been si 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an To the Hospital or Attending Physicien: The iew within 24 hours efter death.

To the Funerei Director: After this certificate hes completely filled in by the funeral director, page 2: autopsy performe of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Stather (Specify) ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA TOMP 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 2 Accident 5 🗌 Pending injury Division 2 🗌 No Investigation 3 Suicide 4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt under Varen MINIS EMPILE 31. Date filed (Month, Day, Year) State

Registrar

JAN 0 4 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ aw UMPR Ecemen Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A BALTIMORE NURSING CENTER GOOD SAMARITAN 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days **X**□ M 2 □ F Hours 8-24-1927 MARYLAND **Director** 219-10-6718 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director PARKVILLE 1 Yes 2 No MD. BALTO. 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 7805 AIKEN AVENUE 21234 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: WHITE 1 Yes X No Specify 3 Widowed 4 □ Divorced Completed Year or Dates. 1946-1947 event, the Medical 15. Decedent's Education (Specify only highest grade completed, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MACHINIST RAILROAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental His marked of 2 ELIZABETH T. BILTZ RICHARD J. TAYLOR 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BROTHER 7 MANOR AVENUE BALTIMORE, MD. 21206 JOSEPH J. TAYLOR 27 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 1-5-2013 BALTIMORE, MD. MOST HOLY REDEEMER 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. Signature of Funeral Service Licensee BALTIMORE, MD. 21206 6415 BELAIR ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No been signed by the should be detached 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🕅 No 24a. Was an SEL autopsy perform or Attending Physician: The certificate Yes 25. Was case referred to medical examiner? completed filled in by the funeral director, Be Division of Vital 26. Place of Death (Check only one) Hospital: 2 No Other: ျပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accide work?
1 Yes 2 No 5 Pending after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my anision, death assume that the Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the F 3 🗆 only one 29b. Signature and title of 29d, Date signed (Month, Day, Year) 3066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 60 do ch Calver 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

4 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death WOODLEY Physician/ DECEMBER WALTER 04:22AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea, 1-10-1926) Country) Director 231-12-5744 1**X**□M 2 □ F 86 VA Usual Residence of Deceden or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Directo MD n/a Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 935 North Franklintown Road 21216 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc à 1 Never Married 2 Married "natural", or filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: African-American Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant: If item 27 is marked other than ' ury or other traumatic event, <u>the Me</u> Elementary/Secondary (0-12) College (1-4 or 5+) 8th & P Bakery Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Woodley Martha Ann Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry Woodley/Son 9932 Linden Hill Rd., Ovings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veterans 1-9-2013 Owings Mills, MD 21. Signatore of Funeral Service 22. Name and Address of Facility Wylie Funeral Home P.A. of Baltimore Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that cused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death SEPSIS Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Pheumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-transit celllymphoma or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the buria Certificate: To Be Completed by Physician/Medical P.O. Box 68760 attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown After this certificate has been sifuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform Yes 2 No 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 D No Other: 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending s after death.

I Director: After the function of the function 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29b. Signature and title of certifier RES-000 December 31 2012 Or 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE MD 21287 Suber 1900 DRLEANS ST 32. **Res** State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G935 1/04/2013 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year 084 Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death 4b. City. Town, or Location of Death Burnse Dwer If Under 1 Year If Under 24 Hrs. Security Number 6 Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Min. (Month, Day, Year) Hours Country) 213-26-3572 Director 1 X M 2 □ F 82 Vrs Sept. 30 1930 MD r then "natural", or itams 23e or 28a-f show the Medical Examiner must be notified at within 72 hours efter death with the Meryland 10a State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 XNo Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 130 Sandy Beach Drive 21122 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black White etc. þ 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filad within 72 ial Hyglane. Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Teamsters Local 557 æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mantal H 27 is markad of traumatic aver t. Paga 1 and 2 should ba fill tmant of Health and Mantal tent: if itam 27 is markad o မ John E. Waters Matilda Ledley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie E. Waters (spouse) 130 Sandy Beach Drive, Pasadena, MD 21122 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department o Importent: if any injury or ò 1 KBurial 2 Cremation 3 Removal from State 04 Jan Maryland Veterans Cem 4 Donation 5 Other (Specify) 2013 Crownsville, Maryland Signature Full eral Serv 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) OFFINAN OWO Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underhing Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burlal-transit or Attanding Physician: The lew requires that the death certificete be executed and resulting in death) Last Due to (or as a consequence of) is after death.

Director: After this certificate has been signed by the attending physician in his the funeral director, page 2 should be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 N Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accider 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be To the Hospitel or Atta within 24 hours aftar der To tha Funarai Directol complately filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 000 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 619 301 05-4 BWMC E.D. HOSPITEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ANO 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 26, 2012 Month December 11:26 A M Walker Constance Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10000 Brunswick Ave. #509 Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 577-52-8541 1 □ M 2 🗓 F 75 Oct. 22, 1937 Washington D.C. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner myst be notified at 10a, State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 10000 Brunswick Ave. **#509** 20910 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2XXNo Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Completed 3 X Widowed 4 ☐ Divorced Black. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Non-profit Organiztion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d Mental F marked o I and 2 should be fill If Health and Mental Item 27 is marked 0 John Randolph Watson, Sr. Annie Lee Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johnnie Walker, Jr. / 21766 Kings Crossing Ter., Ashburn, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State Beltsville, MD Chesapeake Crematory 01/03/2013 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22 Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PANCREATIC CARCINOMA 3 MONTHS Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? 1 ☐ Yes 2XXN 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
1 ☑ Natural
2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After injury 5 Pending neral Director: A filled in by the fi 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ACertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D23308 DECEMBER 31, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Q_{\prime}

Registrar DHMH 17 Rev 06-2011

State

VICTOR M. PRIEGO, M.D.,

31. Date filed (Month, Day, Year)

Box 68760

P.0.

Division of Vital Records.

6410 ROCKLEDGE DR. #660,

20817

BETHESDA, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 10:15 P 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 12 Day 14 Angus Wood Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death
Prince Georges Hill Haven Healthcare Center Aldedhi 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Funeral 225-20-4725 1 X M 2 - F 86 Months Days Hours Min 6/30/1926 Virginia Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits at 10a State 10c. City. Town or Location death with the Maryland Director MD must be notified Prince Georges 1 Yes 2 □ No Aldelphi 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Ь Funeral 3210 Powder Mill Rd items 23a 20783 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11 Marital Status Examiner rmed Forces?

X Yes 2 1 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ö þ 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: "natural" 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Draftsman and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked any injury or need. Angus P Wood Sr. Mozelle Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2912 Brantley Drive Antioch Tennessee 37013 19a. Informant's Name/Relationship (Type, Print) Quidalee Rucker 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cheltenham, Maryland 1/10/2013 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Cheltenham Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility 716 Kernedy St Ny Schington LO Johnson & Jenkins Funeral Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or *Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury that initiated events that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death ed by the detached P.0. cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an autopsy performed? 1 Yes 2 No eral Director: After this certificate I filled in by the funeral director, page 25. Was case referred to medica or Attending Physician: 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: Al 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Hurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) #228 Glenn Dele MS 20769 2200 IAVAKOL, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner , Town, or Location of Death 4c. County of Death 11051 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 415 8572 Hours 07/14/1915 03 TENNESSEE Director 1 □ M 2 🕇 F 97 idence of Decedent or 28e-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director MD HARFORD JOPPA 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 238 2708 CLAYTON ROAD 21085 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces2 1 ☐ Yes 2 ☐ No Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give WHITE Specify: 3 Midowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MECHANIC BOEING AERO. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file I Haalth end Mantel H Item 27 is marked ot ပ္ UNK. WHEELER MAUDE McGLOUTHIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVELYN K. BOWMAN/GRANDDAUGHTER 2708 CLAYTON RD JOPPA, MD 21085 parmit. Page 1 and Department of Haalt Important: If item 2 any Injury or other * Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 01/03/12 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) unga Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine usa as tha burlal-transi Cause (Disease or injury that initiated events resulting in death) Last Cervical Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown To the Funeral Director: Aftar this certificata has been signed by the atte complately fillad in by tha funaral diractor, page 2 should ba datachad for Day g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours aftar death. To the Funeral Director: Aftar this certificata has i autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Set by my steam in the transport of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

□ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pactinore 1 Scholl 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AN 0 4 2013 Registrar

I A BI A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCELLA J. ZEMANSKI Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **BALTIMORE** TOWSON MEDICAL, If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 79 219-28-6408 **Director** MARYLAND 1 M 2 F MARCH 4,1933 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28e-f e must be notified CARNEY 1 Yes 2 No MD. BALTO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 USA 2904 SUPERIOR AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: 3 Divorced 4 Divorced Specify: WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) i Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12TH ADMINISTRATIVE ASSISTANT ENGINEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ MARY ANNA KANIECKI WALTER ANUSZEWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Heeith SUPERIOR AVENUE CARNEY, MD. 21234 **SPOUSE** BERNARD ZEMANSKI 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date rmit. Pege 1 pertment of portent: If it y injury or o DULANEY VALLEY 1 X Burial 2 Cremation 3 Removal from State 1-5-2013 TIMONIUM, MD. 21093 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of) sate has been signed by the attending physicien end pege 2 should be deteched for use as the buriel-trensit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo To the Hospital or Attending Physicien: Within 24 hours effer deeth.

To the Funerel Director: Affer this certific Division of Vital funerel director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 X No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending erel Director: A 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date, and due to the cause(s) and manner stated. 29a, Certifier completely (Check of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:42P DECEMBER 30,2012 ANNA MARIE ZINSER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NOTTINGHAM 8605 HICKORY THICKET PL. **BALTO** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral Hours Days (Month, Day, Year) 92 214-12-0474 Director 1 □ M 2 🔏 F AUG. 22,1920 ITALY 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Evaminer must be notified at 10c. City. Town or Location Director 1 🗌 Yes 2 ื No **NOTTINGHAM** MD. BALTO. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21236 8605 HICKORY THICKET PL. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 ☐ Yes 2 😿 No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GROCERY CASHIER 8TH t of Heelth and Mental Hygi if item 27 is marked other or other traumatic event, Be laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LEPORE Page 1 and 2 should be ADELINA BANCAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8605 HICKORY THICKET PL. NOTTINGHAM, MD. 21236 DTR. NANCY SCHAMMEL timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State important: il any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 1-5-2013 BALTO. MD. GARDENS OF FAITH Signature of Funeral Se 22. Name and Address of FacilitySCHIMUNEK FUNERAL HOME, INC. NOTTINGHAM, MD. 21236 9705 BELAIR ROAD 23a. Part . Enter the disease, or com, lications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) signed by the ettending physicien end d be detached for use es the buriel-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sk completely filled in by the funeral director, page 2 should I 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 **N**0 1 ☐ Yes 2 1 🗌 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Contifying Nurse Practitioner: To the best of my knowledge, Seeth progress at the time, detri and place, and due to the newse(s) and manyer as stated only one 29b. Signature an 29d. Date signed (Month, Day, Year)

State Registrar Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	SI	ate of M	aryiai			te of D		iria iv	ientai ny	Reg. No	20	112	1,28	331
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Examin	er	4a. Facility Name (if not institution							Location of	Death				of Death		_
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but	edical	29a. Certifier 1 Certifyin (Check 2 Medical	g Physician:	To the best of	my know	ledge, death o	ccured a	at the time,	date and pl	lace, an	d due to the ca	ause(s) ar	nd mann	ner as stat	ted. ause(s) and man	ner stated
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Him		30. Name and address of person		ted cause of d		1 23a) (Type, P	rint)		UU			1/5	CVV	W/V/	10)6	-14
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day 11 2012 Month Physician/ 10:05 A.M December Andrea Joan Adams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Derwood Casey House - Montgomery Hospice Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Director D80-40-3966 1 🗆 M 2 💢 F 59 02/21/1953 Oklahoma ye 1 end 2 should be filed within 72 hours after death with the Maryland tof Health and Mentel Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rockville MD 1 🗌 Yes 2 🕅 No Montgomery 10g. Citizen of What Country? 10e. Street and Number Funeral 20850 1235 Potomac Valley Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14, Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 X Never Married 2 Married þ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Veteran's Administrator College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Hospital Planner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Walker Adams Louise Denny Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12181 Flag Harbor Drive, Germantown, MD 20874 Amey L. Adams (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Pege 1 1 Durial 2 X Cremation 3 X Removal from State December permit. Pege Department of Important: If any injury or Metropolitan Crematory 12, 2012 4 Donation 5 Other (Specify) Alexandria, VA 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, RACH Mile Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ a Amyotrophic Lateral Sclerosis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director. After this certificate has been signed by the attending physician and Legompletely filled in by the funeral director, page 2 should be detached for use as the burielthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospital 1 Yes 2 X No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate; (Month, Day, Year) XNatural 5 Pending М Investigation Accident 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signatur and title of certifier 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

DEC 13

Debrah Miller, CRNP, 6001 Muncaster Mill Road, Rockville, MD 20855

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R143201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 201^Y2^{ar} Thomas John Allshouse, Sr. 2114 М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll County Hospital Westminster Carroll If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Director 578-68-4932 1 🖾 M 2 🗆 F 61 10-24-1951 Washington, DC of Mental Hygiene. marked other than "natural", or Items 23e or 28e-f show imetic event, the Modical Examiner must be northed at 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Frederick Mt. Airy 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13406 Autumn Crest Drive 21771 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛛 No Black. White, etc. Completed by 1 ☐ Never Married 2 🌠 Married Maryland 21215-0036 _{Specify}White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Executive U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ David Samuel Allshouse Margaret Schmitt permit. Page 1 and 2 should be Depertment of Health and Mer Important: If Item 27 is mark any Injury or other traumetic traumetic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kit Allshouse / wife 13406 Autumn Crest Dr., Mt. Airy, MD 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Stauffer Crematory 12-13-2012 Frederick, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityStauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd., Mt. Airy, MD 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction hour Medical Due to (or as a consequence of) Éxamine⊦ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that in the cause) Examine Due to (or as a consequence of): To the Hospital or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death.
To the Funerel Director: After this certificate has been signed by the attending physicien end completely filled in by the Innerial director, page 2 should be deteched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Elevated Cholesterol After this certificate has been significate has been significated funeral director, page 2 should it 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) l B Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 No |은 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 🗆 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25947 December 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

State

31. Date filed (Month, Day, Year)

DEC

3 201

Dr. Evelyn Jackson / 5540 Ten Oaks Rd., Clarksville, MD 21029

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b per FH FCHD TM 12/18/12
State of Maryland / Department of Health and Mental Hygiene 42834 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Joyce D. Arrowood December 5:57a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min (Month, Day, Year) Director 213-44-6204 1 M 2 X F Yrs 66 Aug. 11, 1946 South Carolina permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 K No Maryland Frederick Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14809 Harrisville Road 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛛 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes Give 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Receptionist Northampton Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hoyt Morrison Ruth Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tommy Arrowood / Husband 14809 Harrisville Road, Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/11/2012 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Pine Grove Cemetery 12/12/2012 Airy, Maryland. 21. Signature uneral Service 22. Name and Address of Facility
Stauffer Funeral
1621 Opossumtown Homes Pike, P. A Frederick, Maryland 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition nowas Medical Due to (or as a bonso pence 1) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? 5 Other (specify) Day Month 4 Pregnant Pregnant at time of death Year Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 2 No Yes 2 the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 LV No Hospital: Other: 4 Nursing Home 5 PResidence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Accident
Suicide
Homicide Investigation
6 Could not be 2 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Sig nd title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 12-10son who completed cause of death (Item 23a) (Type, Print) 21702 0 31. Date filed (Month, Day, Year) 32. Redis State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 2012 AKA Marie L. Boyd 14. 0839 Maria Dorothy Boyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Med Star Montgomery Medical Center 0Lney Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours January 9,1928 TTTinois Director 436-30-7419 1 □ M 2 🛛 F 84 ed other then "natural", or items 23a or 28e-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo Maryland Montgomery Silver Spring 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 U.S.A 3311 South Leisure World Blvd Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White Specify: 3 → Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. item 27 Is marked other then other treumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Insurance Agency 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anthony Lascara Mary Dagro Pege 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Fallsworth Place, Walkersville, Md. 21793 Patricia A. deLauder Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ŏ 1 Burial 2 Cremation 3 Removal from State Hagerstown Crematory : 12-17-12 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Feneral Service Licens Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Filter the disease, or complications shock or he int failure. List only one cause Immediate ause (Final disease or condit n resulting in death) mat caused the on each line. sighth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physiciani Medical Due to (or as a prosequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မြ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mann of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 🗆 Yes 2 🗆 No 5 Pending м Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗓 Cartifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signal 201 of person who completed cause of death (Item 23a) (IV

State

Registrar DHMH 17 Rev 06-2011 egistrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 12, 2012 2:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Nursing Center Adelphi P.G. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Director 340-20-1339 1 M 2 K F 86 July 16, 1926 27 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 Thistle Court 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X☐ No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify. 3 ₺ Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 | h and Mentel Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Professional Student College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Robert Healy Agnes O'Donnell permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke eny Injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew Bond/Son 3208 Taylor Street, Mt. Rainier, MD 20712 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Dec. 13. 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA 2012 21. Signature of Funeral Service Loenses 22. Name and Address of Facility.
Francis J. Collins Funeral Home Inc.
500 University Blvd. W,. Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Prerenal Azotemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events sician and re burial-transit Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exa Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☑ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Hypertension Records, cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy To the Hospital or Attending Physician: The within 24 hours after death.
To the Funerel Director: After this certificate comparaty filled in by the funeral director, pa 1 Yes 2 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 K Nursing Home 5 Residence 6 Other (Specify) ဂ္ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of 30. Name and address of person who completed vause of death (Item 23a) (Type, Print)
Njideka Udochi, MD 8900 Columbia 1 8900 Columbia 100 Pkwy, Suite G, Columbia, MD 21045

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

d2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month DEC. Physician/ 2012 11:40 AM BARBARA ANN BELL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HYATTSVILLE 5409 GALLATIN ST. PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 214-30-1066 1 □ M 2 □XF 78 MARCH 20,1934 MARYLAND I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 √ Yes 2 □ No PRINCE GEORGE'S BRENTWOOD 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 4514 20722 U.S.A. 38th ST 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. ≥ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 □ Divorced Completed WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ဥ MICHAEL THOMAS ANDERSON FLORENCE MAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 5409 GALLATIN ST., HYATTSVILLE, MD. 20781 GARY BELL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Durial 2 Cremation 3 Removal from State GEORGE WASHINGTON CEM. 12-20-2012 4 Donation 5 Other (Specify) ADELPHI, MD. 21. Signature of Funeral Service Licenses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A MINGULLE MOOO91 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 5 YEARS shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ CARDIOMYOPATHY Medical resulting in death) Due to (or as a consequence of): Examiner 5 YEARS CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence off attending physician and I for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury 10 YEARS CORONARY ARTERY DISEASE that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 24 No
9 Unknown Month Day Year 5 Other (specify) signed by the at the detached f Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛛 No ne Hospital or Attending Physician: The n24 hours after death.

The Funeral Director: After this certificate oletely filled in by the funeral director, pa 25. Was case referred to medical æ 26. Place of Death (Check only one) SON'S Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 ☐ No မူ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hours to the Funer completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title

State Registrar 31. Date filed (Month, Day, Year)

DEC 1 4 2012

B2. Registrar's S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

209A HANDVER PKWY

209A HANDVER PKWY

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12/10/2012 LAURA NOVELLA BURTON 3:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 131 Awkard Lane Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 579-44-4845 Country) Director 1 □ M 2X F 1/23/1922 90 MD nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland entment of Health and Mental Hygiene. ortent: If item 27 is marked other than "natural", or items 23a or 28e-f show Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Montgomerv Silver Spring 1 ☐XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 131 Awkard 20905 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☒XNo 1 ☐ Yes 2 🙀 No Specify: 3 № Widowed 4 □ Divorced Black Specify: Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Domestic-Housekeeper Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Jackson Emma J. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Henson/daughter 14700 New Hampshire Avenue, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Depertment of H Importent: If ite any Injury or ott 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Parklawn Mem. Park 12/17/2012 Rockville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington Street, Rockville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Terminal cardiac arrhythmia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Advanced dementia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year sate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by throat cancer 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autone this certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.
To the Funeral Director. After thi funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie V006591 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amy Schiffman, MD, 9613 Bellevue Drive, Bethesda, MD 20814 31. Date filed (Month, Day, Year) State 13 Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Amend #26, per verbal 6942 846/13 TRT per verbal 6942 1846/13 TRT ent of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Clovis R. Bolen ecember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Haure 9. Birthplac Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Hours Min 127057 1 🕅 M 2 🗆 F 235-30-6768 **Director** Virginia Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Maryland Harford Havre de Grace 1 X Yes 2 ☐ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 749 Tydings Road 21078 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1

X Yes 2

No
If Yes, Give
Year or Dates. WW I I Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Code Administrator Code Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zelphia Jane Hall Levi Bolen 19a. Informant's Name/Relationship (Type, Print)
Ramona Bolen (wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 21078 749 Tydings Rd. Havre de Grace, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location, City or Town, State Aberdeen 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2012 Harford Mem Gdns Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. 21. Sign S.Washington St. Havre de Grace, MD 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Day 1 ☐ Yes ∠ y 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been signe rector, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Ûnknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 1 🗌 Yes Division of Vital Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 No ER/Outpatient 3 DOA 1 🗌 Yes ၉ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 114 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Controlling Number Practionary 1.5 to 2011 of the provided by the cause of the ca (Check 29b. Signature person who completed Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ Ada B. Brooks 2012 11:07 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3895 Shadywood Drive Frederick Jefferson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Hours Director 577-09-4349 1 ☐ M 2**X** F Yrs. Sept. 29,1912 Virginia 100 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 Yes 2 TNo <u>Maryland</u> Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21755 3895 Shadywood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give چ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: 3 ♥ Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) <u>Accounts Payab</u>le Department Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ada Self Samuel Horace Schools 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3895 Shadywood Dr., Jefferson, MD 21755 Jane Lieberman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 12/10/2012 Farnham, Farnham Church Cem. Virginia 21. Signature of Funer S. rvic Cen 22. Name and Address of Facility Stauffer Funeral Home 1100 North Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Districe Colitis Physician disease or condition resulting in death) Clostadiun Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate
Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Meningion 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Z 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 22037

Registrar DHMH 17 Rev 06-2011

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BRUTSWILL MD 21716

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32. Registrar's Signature

PRECIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KINCAND

DEC

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bookstein Physician/ Month KIDIN 5:20 P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel 905 Noah Winfield Terrace Annapolis 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1 M 2 XF 71 Hours Min. 579-66-1209 Director 1941 Germany Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 905 Noah Winfield Terrace 21409 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event at-(Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Thom Charlotte Wilde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 905 Noah Winfield Terrace Annapolis, MD 21409 Charles Bookstein / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State December 14 cemetery, crematory or other pl.
Metro Crematory, 1 Burial 2 X Cremation 3 Removal from State INC. Baltimore, MD 4 Donation 5 Other (Specify) 2012 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MRAGS disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month page 2 should be detached for 5 Other (specify) Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Hospital or Attending Physician; The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performe After this certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? Natural 5 Pending 24 hours af er death. Funeral Director Af 1 Yes 2 No] Accident Investigation filled ir by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) melical Parkway sute 210 Amapolo MD 21401

State Registrar 31. Date filed (Month DEC 17 2012

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Medica Examine				e street and number)			4b. City, Town, or	Location of Death	12	12 12 2012 3:2			
		Bay Ridge	Health				Annapo1			Anne Arundel			
Funeral Director		5. Social Security Nu 190-30-42	227	7. Ag	e (In yrs. la 73	ast birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 6/6/1939			rthplace (State or Foreign puntry) PA	
show	ö	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or l	ocation					10d. Inside City Limits	
Warying 28a-f	Director	MD	Anne Aru	ındel	Chu	rchto	n				1 🗆 Yes 2 🔀 No		
3a or		10e. Street and Num					10f. Zip Code			10g. Citiz	ountry?		
ems 2	Funeral	1106 Gwyr	nne Ave.	12. Was Decedent	Ever in U.S	S. 13	20733 3. Was Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-		4, Race - Am	erican Indian.	
, or it	P		ied 2 🗓 Married	Armed Forces?				Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Rid 1 ☐ Yes 2 🏿 No Specify:			Black, Whit	te, etc.	
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tal Hy	To Be	17. Father's Name (F	First, Middle, Last)					18. Mother's Nam		-			
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permit, rage I and 2 should be throw which it nous after beath with the wallyfair beath with the wallyfair brooks after beath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na William I	Bauman /		PO	Box 189, (733			
or off		20a. Method of Disp 1 🗌 Burial 2 🛭		Removal from State			position (Name of ematory or other plac	ce)	Date		cation - City o		
artmer artmer ortant injury	ŀ		5 Other (Spec		Kal	Las (Crematory	12/1	3/2012	Edge	<u>ewater</u>	, MD	
Impo any once		21. Signeture of Buneral Service Licensee 22. Name and Address of Facility George P. Kalas Fune 2973 Solomons Island Rd., Edgewater											
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ½ 9 ☐ Unknown	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	☐ Ectopic pregnand ☐ Other (specify)	су		2	3d. Date of de Month	elivery Day Year			
gned by	কু	Part II. Other signif	1	contributing to death t			underlying cause giv	ven in Part I.		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown			
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Within To th		29b. Signature and t		2 M		, 3	29c. License				signed (Mon		
N.		30. Name and addre	ess of person who	completed cause of c	leath (Item	23a) (Type					1 1	_	
p.10		Ajit Kuru	ip, 1835	University	Blv	d. E,	Ste. 208	, Hyattsv	ille, M	D 207	783		
State Registra	_	31. Date filed (Month	, Day, Year) , 17 2012	32. Registr	ar's Signal	far	K						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DECEMBER Physician/ BRENTON WILMER BROWN 2012 10:03 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD MEMORIAL HOSPITAL **HARFORD** HAVRE DE GRACE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** JULY 31, 1949 Months 1 X M 2 🗆 F Hours Country)
MARYT AND 220-50-1858 63 Director Usual Residence of Decedent 28a-f shov 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director MARYLAND 1 ☐ Yes 2X No HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral 1844 PULASKI HIGHWAY, LOT 19 21078 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give 6 à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 X Divorced Completed Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) DELI MANAGER 12 GROCERY STORE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HENRY EDWARD BROWN OLETHIA LEWIS permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ERICA BROWN / DAUGHTER 140 REMINGTON CIRCLE, HAVRE DE GRACE, MARYLAND 21078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BERKLEY CEMETERY 12/19/12 4 ☐ Donation 5 ☐ Other (Specify) DARLINGTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

LISA SCOTT FUNERAL HOME, P

552 LEWIS STREET, HAVRE DE

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 21078 Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No g 🗌 Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has l autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 N Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500

DHMH 17 Rev 7/2009

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month PM 1159 Ray Bowers 2012 Medical 100 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days (Month, Day, Year) Hours Director 217-30-6572 1 X M 2 □ F 78 Oct 2, 1934 Maryland Usual Residence of Decedent r than "natural", or items 23a or 28a-f show 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Washington Rohrersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21779 Post Office Box 68 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>۾</u> 1 Never Married 2 X Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 X No Specify: Specify. Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Is marked of 2 Samue1 Bowers Viola Shaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 s of Health a item 27 l Post Office Box 68 Rohrersville Maryland 21779 Doris J. Bowers / wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 of Pepartment of Important: If ite any Injury or ot 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Samples Manor Cem 12/18/2012 Sharpsburg, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro MD 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ neumoma disease or condition resulting in death) mon Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a conse Exami Cause (Disease or injury certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 | Ferance... in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Jascular Delane 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No ဂ္ 1 Dinpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Division of 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 [3 [29b. Signature and title D44996 Dec. 14, 2012 phans Rd Boonsboro

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		(Certificate	of D	eath		Reg. No.		
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	Physicia Medic	al .		Comi lacitor carrait, 2-1							5, 2012	140.77
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mary of			Calvert Memoria		In ura last hirth			rederio				thplace (State or Foreign
	Funeral	1	5. Social Security Number 034-18-6674	5. Sex 7. Age 1 ▼ M 2 □ F	(In yrs. last birth	Months	Days	Hours Mi	in. (Month,	Day, Year)	Co	ountry)
	Director		Usual Residence of Decedent	1 X M 2 L F	85 Y	rs.			11/05	/1927	Mas	sachusetts
	and show	آةِ	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryl 28a-f otifie	rec	Maryland Calve	rt	Solomor							1 ☐ Yes 2 🔀 No
	a or 2		10e. Street and Number			10f. Zip				_	tizen of What Co	
	n with	Funeral Director	155 Swaggers Po			206			/O		ted Sta	
	deat r iten iner r		11. Marital Status	12. Was Decedent E Armed Forces?		If Yes, spec	ent of His	n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Ame Black, Whit	
36	al", o	d by	1 ☐ Never Married 2 X Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 X Yes 2 If Yes, Give Year or Dates	NO	1 🗆 Yes	2 X No	Specify:			Specify: Wh:	ite
9	hours natur lical f	Completed	15. Deceden	t's Education	16a. I	Decedent's Usua (Give kind of wo	al Occupa	ation	working	16b. K	ind of Business	/Industry
218	in 72 e. nan "i	g l	(Specify only highes Elementary/Secondary (0-12)	College (1-4 or 5	i+)	life. DO NOT use	retired)			,,	0 0	
7	ygien ygien her ti	l an h	12			<u>Planner</u>	/ Es		r Name (First, Midd		S. Gove	ernment
gug	e filec ntal H ed ot even	To B	17. Father's Name (First, Middle, La Mark Curran	as <i>t)</i>					rine Mo			
ž	d Mer d Mer mark natic		19a. Informant's Name/Relationsh	in (Type Print)	10h	Mailing Address	(Street s		Rural Route Nun			ip Code)
Ma	2 sho th an 27 is trau		Betty Lou Curra						oad, Sol			
ē,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural" or items 2 be notified at other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition		20b. Place of	Disposition (Nat	ne of		Date		ocation - City o	
Baltimore, Maryland 21215-0036	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S			y, crematory or o			12/19/2012	Sol	omons, Ma	ryland
alti	mit. F partm portal / inju		21. Signature of Funeral Service L		\(\)				Rausch Fur			
Ö	Depar Depar Impo any ir		Frechal Kler	n Hardener				P	.0. Box 60	00, Lus	sby, MD 20	0657
			23a. Part 1. Enter the discase, or shock, or heart failure. List o	complications that caused nly one cause on each line	d the death. Do no	ot enter the mod	e of dyin	g, such as card	diac or respiratory	arrest,		Approximate Interval Between
H	Physician/	8	Immediate Cause (Final disease or condition		ROKE							Onset and Death 2 DAYs
	Medical Examiner		resulting in death)	Due to (or as	a consequence o			1	1			FEW YEARS
	Examino.	e.	Sequentially list conditions,		a consequence o			AMOR	<u> </u>			70.71
	ed nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence o	.,,.							
	ecute and al-trar	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence o	of):						
0	ificate be executed ig physician and as the burial-transit	Nedical		d								
3760	ficate g phy as the	Med	e service					-				
Ö	endin r use	Physician/N	23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 🗆 Ectopic	pregnanc	у		- 0	23d. Date of d	- 11
Вох	death ne att	sici	in the past 12 months? 1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown	at time of death	5 Other (s	pecify) _			-	Month	Day Year
P.O.	is that the death certific igned by the attending be detached for use as	P.	9 Unknown Part II. Other significant condition	ns contributing to death	out not resulting i	n the underlying	cause gi	ven in Part I.	23e. D	id tobacco	use contribute t	to the cause of death?
	es the	l by	HTN, HY						, 1	☐ Yes 2	!□No 3 🗗	Probably 4 🗆 Unknown
rds	require been si should	etec							24a. V	/as an		utopsy findings available
ဝ၁	has k	Completed							a	utopsy erformed?	death?	completion of cause of
Ä	sician: The lav certificate has irector, page 2		25. Was case referred to medical	T .			26. P	lace of Death (0	1 \\ Check only one)	es 2 N	10 1 Y	es 2 No
/ita	ysician: is certific director,	To Be	examiner?	Hospital:	ient 2 🗆 ER/Ou	itpatient 3 🗆 🗈	Oth		ng Home 5 🗆 F	esidence	6 Other (Spe	ecify)
of Vital Records,	ख १ ह		27. Manner of Death	28a. Date of inju	ury 28b. T		28c. Injur	y at	28d. Descri			
no	ttending F death. ctor: After y the funer	lical	1 Natural 5 Pendir 2 Accident Investi	gation		М		Yes 2 No				
Division	l or Attend after death Director: A	Certificate:	3 Suicide 6 Could 4 Homicide determ	inad 28e. Place of In	jury - At home, fa tc. (Specify)	rm, street, factor	y, office			n (Street ar Town, State		?ural Route Number,
Ö	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b			Physician: To the best o	f mu knowloda	death acquired	at the tim	e date and nia	ace and due to th	e cause(s)	and manner as	stated.
	Hosi 24 hc Fune etely 1	Medical	(Cheek 2 Medical F	Physician: To the best of ixaminer: On the basis of Nurse Practitioner: To the	evamination and/o	r investigation in	my opini	on, death occur	rred at the time, da	ate and plac	e, and due to the	e cause(s) and manner stated.
	Fo the within Fo the complex c	Σ	only one) 3 La Certifying 29b. Signature and title of certifie		Social in Milos			e number		29d. D	ate signed (Mor	nth, Day, Year)
			> 5	2		I	36	969		12	116/1	
·	~.)		30. Name and address of person SCAR (A MATH	who completed cause of	death (Item 23a) (Type, Print)	MAN	RD LI	ZBY MT	100	(5)	
d	en 6+1		Od Data Stand (Month Doy Ward)	* 00 Doniek	rod Cimpaturo							
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rays Signature	A Son	a Real					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Der Juana Francisca Guevara Vda de Cruz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5422 Taussig Road P.G. Bladensburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-49-9686 Director 1 M 2 X F 81 El Salvador July 11, 1931 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Bladensburg MD P.G. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5422 Taussig Road 20710 El Salvador 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No 3altimore, Maryland 21215-0036 White 1 Yes 2XXNo If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 h n and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Claros Velasquez Francisca Guevara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) and 2 sl Health a tem 27 i 5605 Helmont Place, Oxon Hill, MD 20745 Jose Santos Cruz/Son Department of Hear important: If it any init. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dec. 17 Cemetery crematory or other place)
Cementerio Central
de Pasaquina La Union 1 X Burial 2 Cremation 3 K Removal from State 2012 Pasaquina La Union, 4 Donation 5 Other (Specify) 21. Signatu Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Isdemic Physician/ END-Stage disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Day Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autonsy after death.

Director: After this certificate 1 Yes 2 No Yes 2 1 N funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending 1 Natural 1 Yes Accident 2 No Investigation completely filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5703 Baltimore NSRajapaksemo 2835

DHMH 17 Rev 06-2011

State Registrar 32 Registrar's Signature

(mIM

			Please ¹	Type or Print in Black In AMEND ITEM#5 Der FH. State of Maryland 7 Dep	ndelible Inl ,G936,2/6 artment of F	k. Ensure A /2013 WS Health and M	II Copies Mental Hya	Are Legible).			
_			State Registrar	Cei	rtificate of L			leg. No. 2012	2 42847			
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Janet Goodric	ch Chapman			2. Date of Deatl Month Decembe	e of Death o				
	Exa.nin		4a. Facility Name (if not institution, give si Suburban Hospit		4b. City, Town, or Bethe	r Location of Death		4c. County of Dea				
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) M 2X F 90 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, May 26,	Year) C	irthplace (State or Foreign country) WYORK			
	faryland Ba-f show	Director	10a. State 10b. County Maryland Montgom	10c. City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No			
	with the N 23a or 2	Funeral Dir	10e. Street and Number 5550 Tuckerman		10f. Zip Code	20852		10g. Citizen of What C	Country?			
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hyglene. Important: If tem 27 is marked other than "natural", or Itams 23a or 28a-f show any Injury or other traumatic event, the Medical Expiration in the control of once.	व	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	1 ☐ Yes 2 12 No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2兆 No	lispanic Origin? (Specan, Mexican, Puerto F	14. Race - Am Black, Whi Specify: Wh	erican Indian, ite, etc.				
21215-(within 72 hou giene. er than "natu , the Medic."	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	de completed) (Give life. D	dent's Usual Occup. kind of work done o OO NOT use retired)	during most of workir	ng	16b. Kind of Business				
/land ?	d be filed w Mental Hyg arked othe atic event,	10	17. Father's Name (First, Middle, Last) Carter Goodrich	_		18. Mother's Name Florence	e (First, Middle, M					
e, Man	and 2 should Health end N Em 27 Is ma ther trauma		19a. Informant's Name/Relationship (Type Hazel Perry Chap	oman(Daughter Gar		and Number of Rural LWOTTH & TK, MD 2	Route Number, 6	City or Jown, State, Z	ïp Code)			
Baltimore, Maryland 21215-0036	permit. Page 1 s Department of F Important: If ite any Injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☒ Donation 5 ☐ Other (Specify) 2 ─ Signal re of Funeral S → vice L censee	Georgeto	matory or other place Own Univ	Decem	nber5 W	20c. Location - City o Mashingto Mortuary				
ä	Der Bray	(()	() Xwt- blue	M00969 9	9013 Ann	apolis R	Rd. Lan	ham, MD	20706 P.A.			
	nysician/ Medical		23a. Fart 1. Enter the disease, or complications of the control of	ications that caused the death. Do not enter e cause on each line. a. Due to (gras a consequence of):	Heart 1	Failure			Approximate Interval Between Onset and Death			
	Examiner	iner	Sequentially list conditions, bif any, leading to immediate cause. Enter Underlying	Duy to or as a consequence of):	e Lara	fiorascu	ular a	lisease				
	se executed clen end clen end clen end	al Examiner										
3760	ificere pring physik es the t	Medic	d d	1.								
). Box 68760	or Attending Prysician: The law requires that the deeth certificate be that death. Airer death. Director: After this certificate has been signed by the ettending physic in by the funeral director, page 2 should be detached for use as the bit in by the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1	Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year			
Division of Vital Records, P.O.	requires thet the der been signed by the e should be detached	হ	Part II. Other significant conditions conf	ntributing to death but not resulting in the u	inderlying cause giv	ren in Part I.			co use contribute to the cause of death?			
Recor	sician: The lew re certificate has be lirector, pege 2 sh	Completed					24a. Was an autopsy perform	y prior to ned? death?	utopsy findings available completion of cause of			
/ital	ysician is certifi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital: 1 □ Inpatient 2 🕅 ER/Outpatien	T-:	ace of Death (Check o	, , , ,					
ot	ding Phys h. After this funeral di	ate: 1	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury work	/ at 2	ne 5 ∐ Residen 8d. Describe how	nce_6 Other (Spec w injury occurred	zify)			
ivisior	I or Attend after death Director: A d in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	M 1 🗆 '	Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,			
		न क	(Uneck ∠ ∟ Medicai Examine	cian: To the best of my knowledge, death o er: On the basis of examination and/or investi Practitioner: To the best of my knowledge,	tigation, in my opinio	n, death occurred at t	the time date and	nlace and due to the	cause/s) and manner stated			
ا ا	Within Within		29b. Signature and title of certifier		29c. License			d. Date signed (Monti				
			30. Name and address of person who com	mpleted cause of death (Item 23a) (Type, Pr	mnt) NINA	M. DRic	11125 Ro	ockville P MD 20852	ike #110			
	Stat Registra	_	31. Date filed (Month, Day, Year) JEU 14 2012	A LACHTCH	21	ROC	KVIIIE,	<u> </u>				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUN LU CAI 17:22 <u>/2012</u> Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montagmery 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours (Month, Day, Year) Director 1 X M 2 🗆 F 138-98-5500 89 7/10/1923 China 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgamery Clarksburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22<u>444 Brick Haven Way</u> 2087] 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give \mathcal{C}_{ab} , $\mathcal{J}_{WN}/_{L_{c}}$, $i_{\mathcal{A}}/_{q}/_{g}$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3X Widowed 4 ☐ Divorced Completed Year or Dates Chinese 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Medical Doctor Medicine 1 and 2 should be filed with f Health and Mental Hygien item 27 Is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Zhen Ya Cai Shan Conq Li 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rong Cai - daughter 22444 Brick Haven Way, Clarksburg, MD 20871 Department of Healti Important: If item 2 any injury or other tonce. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Pk 12/14/2012 Rockville, MD Signature of Funeral Service Dicensee 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Anemia due 40 acute Medical Due to (or as a consequence of) Examiner Securitially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due touor as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been simpled. that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pancreatitis 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 14 No မ 1 Minpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 4 house December 10,2012 74336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD 9901 Medical IGBINOSA MOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 3 Registrar

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 42850 1 - For State Amend 20b, 20c Registrar DOR, 12/18/12 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chase 5:00 PM 2072 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Dorchester Cambridge Bay Nursing Wallard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Social Security Number **Funeral** 7-44-1630 1 ▼ M 2 □ F Months Days Hours Min. Mary/and Director VOV. Usual Residence of Decedent 10c. City, Town or Location 28a-f shov 10b. County 10d. Inside City Limits 10a. State Medical Examiner must be notified at Funeral Director 1 Yes 2 No Talbot 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with the Bellevue items 23a 662 215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No / 90 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 No 1967 0 þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working alth and Mental Hygiene.
27 is marked other than "r
r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ rase permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd. Royal Oak, Maryland 2/662 Valerie 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Richard Story Mein Park 1 Burial 2 Cremation 3 Removal from State Easton, MD 12/19/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address Facility Home, P. Cambridge MP. 21613 NA naton Washi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final failure Physician/ renal month disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner cardiovascular discose 2th leroscierotic Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No jo Year Month Day Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at nours after death.

neral Director: After the filled in by the funeral 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours at To the Funeral D completed filled in Hospital Medical [VCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier HO059973

Registrar

State

100 Bramble

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lohnson

Registrar's Sign

etriti

31. Date filed (Mo

18. Mother's Name (First, Middle, Maiden Surname) 21061 20c. Location - City or Town, State Glen Burnie, Md. Forest Dr. Annapolis, Md. Approximate 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2X No

Maryland

1534 м

DHMH 17 Rev 06-2011

State Registrar 7310

gistrar's Signatur

UP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 AACO HEARIH DEPT. OMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month WILLIAM JOSEPH CLANCY JR 11:45 A^M Medical DEC 2012 4a. Facility Name (if not institution, give street and numberWALTER REED Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL MILITARY MEDICAL CENTER MONTGOMERY BETHESDA Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 033-22-4977 Usual Residence of Dece 1 X M 2 □ F 80 04/19/1932 Massachusetts 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Bowie 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2605 Ainsworth Terrace 20716 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ⚠ Yes 2 ☐ No 1- No Black, White, etc. δ ed 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 1956-72 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William J. Clancy, Sr. Margaret O'Neil t. Page 1 and 2 should b tment of Health and Mer rtant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Clancy / Wife 2605 Ainsworth Terr., Bowie, MD 20716 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date UNK permit. Page 1 Department of Important: If if any injury or o once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Arlington Nat'l. Cem. Arlington, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fineral Fervice 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Onset and Death disease or condition PNEUMONIA Medical resulting in death) Due to (or as a consequence of): Examiner MULTISYSTEM ORGAN FAILURE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Divir to for as a consequence of sician and burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 🗆 No 1 🗌 Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Certificate: To 1 ☐ Yes 2 🔀 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending iniurv work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation filled in by the Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral Completely filled Hospital 6 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my opinion double on the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

roug

AINSWORTH, MD

CRAIG R.

31. Date filed (Month, Day, Year) DEC 17

BETHESDA, MD 20889

30. Name and address, of person who completed cause of death (Item 23a) (Type, PrintWALTER REED NATIONAL

Registrar's Signature

DEC 13 2012

MILITARY MEDICAL CENTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 42853 State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Dea 3. Time of Death Physician/ .50AM Medical 01 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death HARWOOD Examiner 4c. County of Death MANDRIN INPATIENT CARE CENTER ANNE ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 79 Hours Min. Country) 564-44-9327 Director 1 M 2 D F 3/22/1933 MISSOURI ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d Inside City Limits Director ANNE ARUNDEL CROWNSVILLE MD 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 111 SUMMERHILL TRAILER PARK 21032 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. à 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Divorced 4 Divorced Specify: WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AEROSPACE ENGINEER ENGINEERING I and 2 should be filed with f Health and Mental Hygien item 27 is marked other th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ൧ HARRY JAMES CARMER MILDRED MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 111 SUMMERHILL TRAILER PARK CROWNSVILLE, MD 21032 DARLEEN ROYE CARMER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot Date 20c. Location - City or Town, State Page 1 CHESAPEARE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 12/14/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) Name and Address of Facility LASTING TRIBUTES BY FELLOWS. LLFENBEIN, & NEWNAM FUNERAL & CREMATION CARE 4 BESTGATE RD. ANNAPOLIS, MD 21401 Signature of Coneral Service Licensee Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ONTHS Physician/ STAGE RENAL END disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Uniknown After this certificate has been so funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed? 2 No 1 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes Other: HOSPICE 2 110 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury ours after death.

leral Director: Aft
filled in by the fur Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 - 1 ac 30. Name and address of person who comp of death (Item 23a) (Type, Print) EFENSE HWY, ANNAPOI UE LOR £5

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ CORNISH ELLA 2012 December Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner ambridge Dorchester Dorchester General 8. Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 1 Year If Under 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 🗆 M 2 🗹 F 78 Days Min. Mary land Hours **Director** or 28a-f shov 10a. State 10d. Inside City Limits 10c. City, Town or Location death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Dryes 2 No ambrida 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 61 reenwood 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc 9 1 Never Married 2 Married Completed by Specify: Black 1 Yes 2 No If Yes, Give Year or Dates "natural" 3 Widowed 4 Divorced 72 hours 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. Electroni Worker should be filed w and Mental Hygi is marked othe Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland P 0 t. Page 1 and 2 should be treent of Health and Mercant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) t e Department of Healtl Important: If item 2 any injury or other I timore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Cometery "ambridge 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address f Facility
17 enry funeral
510 Washin Home, P.A. 21. Signature of Funeral Service Licenses ambridge S 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Pronony Q Medical resulting in death) ence of disc Examiner Cerebro / Vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical P,O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death 5 Other (specify) 9 Unknown be detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖊 Unknown Records, Obstructiv Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an diag autopsy certificate has page 2 perform 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Division of Vital funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After 1 🔼 Natural 5 Pending 1 Yes 2 No To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D 69234 12 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 BYRN STREET CAMBRIDGE MARYLAND ERRABOLU 503 JEEVAN 31. Date filed (Month, Day, Year)
DEC 13 2012 State

Registrar

Criswell, Marjorie A.

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	Funeral		5. Social Security Number 6.	eeders Memorial Home Boonsboro al Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Boonsboro							Washington Birth 9. Birthplace (State or Foreign					
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the state	ems 2	une	141 South Main 11. Marital Status	Street 12. Was Decedent E	ver in U.S	s. T	13. Was De		1713 panic Origin? (S	pecify Yes or No to Rican, etc.)	-		. S . A	S.A. American Indian,		
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30X	e atten d for u	iciar	in the past 12 months? 1 Yes 2 No	1 Live Birth 4 Pregnant a			3 Ectop 5 Other	ic pregnancy (specify)				Month		Day Year		
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	120		30. Name and address of person who	completed cause of d	eath (Item	23a) (Ty	pe, Print)			ן ביורול						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Earl Bruce DRIGGERS December 11, 2012 8:49 a.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington 10016 Melody Lane Hagerstown 5. Social Security Number . Age (*In yr*s. *las* last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1953 1 🛣 M 2 🗆 F Months Hours Director 220-54-4762 Feb. Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director notified Maryland Hagerstown Washington 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ř pe 23a items 23a ier must b 21740 USA 10016 Melody Lane 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. ō 1 ☐ Never Married 2 🗷 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) truck mfg. machine shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Curtis Louis Driggers Rosa Lee Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10016 Melody Lane, Hagerstown, Maryland 21740 Health a tem 27 i Louise Driggers - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Hagerstown, Maryland 12/14/12 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem.Park Signature of Funeral Service Ligensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Day signed by the a 2 No g Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pendina 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in a stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 4641

Registrar

State

OPAI

21740

and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar 42857 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OIY2 AM Marvin Royer DOUGLAS Dec 901.9 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Meritus Medical Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Director 1 🛛 M 2 🗆 F 219-36-3261 73 Oct. 2 1939 Maryland items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 Winding Oak Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 X Married ō ģ Baltimore, Maryland 21215-0036 filed within 72 hours after tal Hygiene. d other than "natural", o 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Crib Maintenance Aluminum Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o 2 Dorothy unknown Charles R. Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 Winding Oak Drive, Hagerstown, Md. 21740 <u> Sue L. Douglas – wife</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/2012 Myersville, Maryland leasant Walk Cem. 21. Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ fours Medical Due to (or as a cons-Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Clostridium Difficile Celitis physician and s the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Box 68760 as attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Chronic atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has I autopsy performed Yes 2 Gastro-intertinal Steedings 2 No 1 Tes Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation To the Hospital or Atter within 24 hours after dea To the Funeral Director completely filled in by th Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of gentifier 29d. Date signed (Month, Day, Year) 29c. License number December 17, 2012 D44996 30. Name and address of serson who completed cause of death (Item 23a) (Type, Print) Rondsoro MD 21712 31. Date filed (Month, 32 Registrar's Signatur State Registrar

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DHMH 17 Rev 06-2011

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			State of Maryland	d / Depa	rtment of H	lealth and	Mental Hy	giene		
_		_	= State Registrament #18perFH, 12/20/12; BMW, McCo		Reg. No. 20 2 4285					
	Physicia		Decedent's Name (First, Middle, Last) Jack DICH	TER			2. Date of Dea	Date of Death Month ecember 10, 2012 3. Time of Death 6:15 A		
men	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Dea		4c. County of Death		
-	'		Suburban Hospital		Bethes If Under 1 Year	da If Under 24 Hrs		Montgom		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	h g. Bi v, Year) Co	rthplace (State or Foreign ountry)					
			Usual Residence of Decedent 93				Nov. 5	, 1919 Pen	nsylvania	
	ryland -f sho ied at	Director		Town or Loc	Spring				10d. Inside City Limits 1 ☐ Yes 2 Ϊ No	
	or 28a	Dire	10e. Street and Number	11701	10f. Zip Code			10g. Citizen of What C		
	with the same same same same same same same sam	Funeral	10118 Hereford Place			0901		United St	-	
	death items nerm		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. V	/as Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi		
36	s after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ X Yes 2 ☐ No If Yes, Give Year or Dates.		☐ Yes 2 🕅 No				hite	
2-0	hours 'natur' dical l	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	ent's Usual Occupa ind of work done d	ation	arking I	16b. Kind of Business	s/Industry	
121	thin 72 ine. than '	mo	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	NOT use retired)	uring most or we	, ning	Diamon		
9	led wi Hygie other ent, tl	Be	17. Father's Name (First, Middle, Last)	Phar	macist 	18. Mother's Na	me (First, Middle, SOI kOTT	Pharmacy Maiden Surname)		
/lan	d be fi Mental arked atic ev	မ	Herman Dichter			Mary	FOTKOFF	-		
altimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Darlene Morning, Daughter					r, City or Town, State, Z Park, MD	ip Code) 20912	
re,	1 and of Heal item		20a. Method of Disposition 20b. Pla	ace of Dispos	sition (Name of atory or other place	1	Date	20c. Location - City o	r Town, State	
iii	ment c		4 Donation 5 Sther (Specify)	Lebar	on Cemet		13/12	Adelphi, M	D	
Ball	permit Depart Import any in		21. Signature of referral Service 14.0101	- 110	Name and Addres					
			23a. Part 1. Extended the disease, or complications that caused the death.	Do not ente	4 Carrol the mode of dying	St., g, such as cardia	W. Washi c or respiratory arr	ington, DC	20012 Approximate	
	Physician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Arterioscler	otic (andiovae	cular D	02502		Interval Between Onset and Death	
9	Medical Examiner		resulting in death) Due to (or as a consequence)	ence of):	LL MILITAGE	Later Colonia	iscuse			
3		Jer	Sequentially list conditions, b. Due to for 35 3 00 5 cg/like	nte og:						
20	Tansit uted	amir	If any, leading to increadate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
Sb15am	e be executed sysician and ne burial-transi	a E	resulting in death) Last Due to (or as a conseque	ence of):						
(0	cate b	edic	d				-			
(687	certifi anding use a	Ju /M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal		Ectopic pregnance			23d. Date of de	elivery	
7 Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	in the past 12 months? 1 Yes 2 No 9 Unknown in the past 12 months? 4 Pregnant at time of de		Other (specify)	y 		Month	Day Year	
10, P.O.	hat the ed by 1 detacl	by Ph	Part II. Other significant conditions contributing to death but not resu	Iting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	o the cause of death?	
ds, I	quires t	ed b					1 🗆 🕆	Yes 2□No 3□F	Probably 4 Unknown	
\mathcal{D} Records,	law red nas be e 2 sho	Completed					24a. Was autop	sv prior to	utopsy findings available completion of cause of	
Re	n: The ficate h		25. Was case referred to medical				1 🗆 Yes	rmed? death? 2 No 1 Ye	es 2 🗆 No	
OCK Vital	Physician: this certific aral director,	To Be	examiner? 1 Yes 2 XNo Hospital: 1 Inpatient 2 VI	R/Outpatien	_ Tothe	er: 4 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		lence 6 Other (Spe	cify)	
6	ng Phy fter thi ineral			28b. Time of injury	28c. Injury work	at		ow injury occurred	<i>,</i>	
Sion	Attending or death. ector: After by the fune	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	ae farm etre		Yes 2 No	29f Location (C	treet and Number or Ru	ural Pauta Alumbar	
	al or A s after al Direct		4 Homicide determined building, etc. (Specify)	ic, iairi, sire	et, lactory, office		City or Tow		arar noute Namber,	
<u>う</u>	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check 2 Dectifying Physician: To the best of my knowle Addical Examiner: On the basis of examination	and/or investi	gation, in my opinio	n, death occurred	l at the time, date a	nd place, and due to the	cause(s) and manner stated.	
0	To the within To the comple	Σ	only one) 3 L Certifying Nurse Practitioner; To the best of my 29b. Signature and title of certified.	/ Knowledge,	29c. License			ne cause(s) and manner 29d. Date signed (Mont	th, Day, Year)	
	4+1		F. W. Landon M		D 1	9085		12/10	12012	
			30. Name and address of person who completed cause of death (Item 2 Frederick W. Randolph, M.D., 86	23a) (Type, P 00 01 c	l Georget	own Road	d, Bethes	sda, MD 20	814	
	Stat Registra		31. Date filed (Month, Day, Year) OEC 13 2012	· pa	Kel					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Physician/ owns 2 Jui 2 Medical 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** ledica Anne Annapolis 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Director 1 **X** M 2 □ F 62 2 1950 ms 23a or 28a-f shormust be notified at 10c. City, Town or Location Director Marvland Anne Arundel Arno1d 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 380 Volley Ct. 21012 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 1070 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 ☐ Never Married 2X Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 1970 – 71 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Program event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Servpro of Elementary/Secondary (0-12) College (1-4 or 5+) Annapolis 12th Manager Supervisor Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) id Mental I ပ Lloyd A. Downs Sr Pearl Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Margaret L. Downs(Wife) 380 Volley Ct. Arnold, Md. 21012 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Maryland Veterans 12-18-12 1 X Burial 2 Cremation 3 Removal from State Crownsville, Md. 4 Donation 5 Other (Specify) Miname aRaces of Soliit Sons Mortuary, P.A. 21, Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a resulting in death) Last the attending physician Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 Yes 2 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 autopsy 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in rity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title D50605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2661 Riva Rd, Ste 610, Annapolis, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Maryland

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Dav

1 Yes 2 No

3 Probably 4 ☐ Unknown

Onset and Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

DHMH 17 Rev 06-2011

State Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 01251 Physician/ Month cemper Medical acility Name if not institution, give street and nu City, Town, or Location of Death Examiner 4c. County of Death N/A 8. Date of Birth (Month, Day, Year) NOV 5 1996 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Hours Min Maryland 213-49-9311 Director 1 □ M 2X F 16 Yrs. 28a-f shov 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10d. Inside City Limits event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2X No Mary1and Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 306 Colby Circle 21060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. 9 Completed by 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Glen Burnie College (1-4 or 5+) Elementary/Secondary (0-12) Student High School 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Anthony D. Devonshire Tykitra Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21060 306 Colby Circle Glen Burnie, Md. permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Tykitra Jacobs(Mother) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 12-17-12 Baltimore, Md. Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Winname a Rose Rescot Recitions Mortuary, P.A. 21. Signature of Funeral Service Licenses 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Day Month 5 Other (specify) is certificate has been signed by the a director, page 2 should be detached 1 L Yes 2 L 9 Unknown Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 🗌 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 2 🗌 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier 1 Equitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JAMES LEE DARAGO 1:45P 2012 DECEMBER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PETER'S CHURCH ROAD WALDORF CHARLES 3200 ST. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 219-17-4233 32 JULY 21,1980 WASHINGTON, DC th and Mental Hyglene. 27 is marked other then "neturel", or items 23e or 28e-f show traumatic event, the Madical Examination at the matter 10a. State 10b, Count 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2XXNo MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3200 ST. PETER'S CHURCH ROAD 20601 S. Α. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Armed Forces ģ 1 Never Married 2 X Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) AUTO BODY TECHNICIAN AUTO REPAIR SHOP Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 2 DANIEL LEE DARAGO BRENDA JOY WYATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health sitem 27 I ERICA DARAGO/SPOUSE 3200 ST. PETER'S CHURCH RD., WALDORF, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I cemetery, crematory or other place, 5 1 Burial 2 Cremation 3 Removal from State injury 4 Donation 5 Other (Specify) METRO. CREMATORY 12/18/2012 ALEXANDRIA, VA 21. Signature of Funeral Service Li 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. 5 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Exami ettending physicien and I for use as the burial-transit Hospital or Attending Physician: The lew requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ecompletely filled in by the funeral director, page 2 should be detached for 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital: 1 Tes 2 No |은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work?
1 Yes 2 No М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature and #tle of certifie 10 SM on who completed cause of death (Item 23a) (Type, Print) 8 (EAKA

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 PState of Maryland Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DECEMBER 2012 18 ETHYL MAE DUBOIS 9:35A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CHARLES WALDORF <u>2706 WHISTLING COURT</u> 8. Date of Birth Sept. 08, 1937 DEC. 18, 2012 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Director 143-30-3763 1 M 2XXF 75 NEW JERSEY or then "neturel", or items 23e or 28e-f show 10a. State 10b. County 10c. City, Town or Location filed within 72 hours efter death with the Maryland Director 10d. Inside City Limits 1 Yes 2 No CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2768 MORAN DRIVE 20601 S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 160—162 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATOR P.G.COUNTY SCHOOLS permit. Page 1 and 2 should be filed w Department of Health and Mentel Hyg Importent: If item 27 is marked othe eny injury or other traumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ MELVIN DUBOIS HELEN SPRAGUE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOAN DUBOIS / SISTER 4113 GLORIA LANE, BETHLEHEM, PENNSYLVANIA 18017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MD VETERANS CEMETERY 12/21/2012 CHELTENHAM, MARYLAND 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Signature of Funeral Service Licens M00641 5635 WASHINGTON AVENUE, LA PLATA, MARYLAND 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The lew requires thet the deeth certificate be executed within 24 hours efter death.

To the Funerel Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funerel director, page 2 should be detached for use as the buriel-trensit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hmknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) FRIEND S 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred RESIDENCE 1- Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Left Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

4 2013

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

05

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 George Meade Eyler December 9:45 p.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Emmitsburg Frederick St. Catherine's Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number **Funeral** 6. Sex 9. Birthplace (State or Foreign 1 X M 2 100 Sept 6, Mary I and 220-30-7717 **19**12 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Frederick Thurmont 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with 21788 USA 36 Blue Ridge Avenue 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces Black, White, etc þ 1 Never Married 2 Married Yes 2 X No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: white If Yes, Give "natural", 3 XWidowed 4 ☐ Divorced Completed Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Robert David Eyler Lula M. Trout permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018013324 Berlin Turnpike, Lovettsville, Virginia Patricia Raymond - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 12/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Emmitsburg Memorial Emmitsburg, Maryland 22. Name and Address of Facility Stauffer Funeral Home Sig ure of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause an each line. ch as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical e to (or as a consequence of): Examiner Signs tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ce of): Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician a Medical Box 68760 ed by the attending properties of the perfection of the second se IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Unknown P.O. signed by tall Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Records, 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 🗌 No certificate 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 X No 1 🗌 Yes ျ ☐ Inpatient 2 ER/Outpatient Nursing Home 5 \square Residence 6 \square Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Del 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 2 Accider 5 Pending work Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 31. Date filed (Month, Day, Year)

only one)

29b. Signature



cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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Emmits burg

Day, Year)

2172

12-09766

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 42854

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Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	- Cortinoato or De		Reg. N 2. Date of Death		3. Time of Death
Medical Examine	Pedro Calderon Funes			Month Da December 22	y Year 2, 2012	1758 hrs
	4a. Facility Name (if not institution, give street and number	· .	ity, Town, or Location of Deat	h	4c. County of Death	
	Washington Adventist Hospital		koma Park		Montgomery	
Funeral Director		M	Under 1 Year If Under 24Hr onths Days Hours Mir		IM/DD/YYYY) 9. Birth Foreign	
Director	None 1x M 2 F	57 Yrs		June 28,	1955 E Cou	^{ntry)} Salvador
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
* "	MD P.G.	Hyatts	v.411.			1 Yes 2 No
Maryland 28a-f show d at once. ector	10e. Street and Number		. Zip Code	10g. (Citizen of What Count	ry?
th the Maryland 23s or 28s-f sho notified at once.	8104 14th Avenue		20783		El Salva	ior
5-0036 ed within 72 hours after death with the Maryland stygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once Completed by Funeral Director	11. Marital Status 12. Was Deceder	nt Ever in U.S. 13. Was De	cedent of Hispanic Origin? (S		14. Race - Americ	
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5-00 illed with Hygien d other the Me	17. Father's Name (First, Middle, Last)	Dabole		e (First, Middle, Maid		LOII
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D 21 should and Med 7 is man	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Add	ress (Street and Number or	Rural Route Number,	, City or Town, State,	Zip Code)
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumatin	Bernarda Calderon/Mother 20a. Method of Disposition	8104 14	th Avenue, Hya		MD 20783	Gum State
imore, MD 2121 Pages 1 and 2 should be fi nent of Health and Mental iant: If item 27 is marked or other fraumatic event, To Be	1 Burial 2 X Cremation 3 Removal from S		1	ec. 27,	c. Location - City of 1	OWII, State
limore Pages 1 ment of F tant: If	4 Donation 5 Other Specify:	Metropolitan	Crematory	2012 A	lexandria	, VA
Baltimore, permit. Pages 1 at Department of Hee Important: If ite	21. Signature of Funeral Service Licensee	Fran	and Address of Facility Cis J. Collins	s Funeral	Home Inc.	
Physician	23a. Part I. Enter the disease, or complications that cause	1 500 d the death. Do not enter the m	University Bly ode of dying, such as cardiac	or respiratory arrest,	1ver Spri	pproximate Interval
Medical	failure. List only one cause on each line.					Between Onset and Death
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Box 6876 death certificate the attending phy of for use as the b	past 12 months?	at time of death 5 Other (•
by the attending pluched for use as the Physician/	1 Yes 2 No 9 Unknown 9 Unknown					
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ords, aw requir as been s 2 should i				autopsy performed	prior to co	mpletion of cause of
				1 ✓ Yes 2	No 1 ✓ Yes	2 No
Vital Revysician: The his certificate director, page	25. Was case referred to medical examiner? Hospital:		26.Place of Death (Check			
# # # # H	1 Yes 2 No Inpat 27. Manner of Death 28a. Date of In	ient 2 ✓ ER/Outpatient 3 iury 28b. Time of Injury	DOA Other Nursi 28c. Injury at Work?	ng Home 5 Res	idence 6 Other:	
on of ading Ph	1 Natural c (Month, Day	(Year)	4 Van 2 Van	subject f	ound at b	ottom of
	28e. Place of	2-12 fd 16:58 p Injury - At home, farm, street, fac		stairs 28f. Location (Stree	et and Number or Rura	al Route Number, City
Division o spital or Attending nours after death neral Director: After filled in by the func Certification:	Suicide 6 Could not be determined (Specify)	Laundry Room		or Town, State	8112 New E tsville,MD	lampshire •
	29a. Certifier 1 Certifying Physician: To the best of	my knowledge, death occurred a		d due to the cause(s)	and manner as state	i.
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of exand manner stated	amination and/or investigation, i l.				
≥ ادیان	29b. Signature and title of certifier		29c, License number		d. Date signed (Moni	
	auet 2		O.C.M.E.	D	ecember 23, 20	12
	30. Name and address of person who completed cause of	death (Item 23a) lical Examiner 900 W.	Raltimore Street Rolti	more MD 2122	3	
						· · · · · · · · · · · · · · · · · · ·
State Registra	1161 0 7 9019 12	ar's Signature				

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42865 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Jean Elizabeth GILBERT 5:15 p. M December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery Hospice Casey House Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 217-12-2115 89 Director 1 M 2 T F April 13,1923 Maryland Usual Residence of Decede 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Silver Spring Montgomery 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral 15021 Wellwood Road 20905 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) secretary aircraft mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, George Edgar Harne Anna Isabelle Bowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca L. Miller - daughter 15021 Wellwood Rd., Silver Spring, Md. 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State ò Rose Hill Cemetery 12/15/12 injury o Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licens . Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ lung cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death 1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🛣 Probably 4 ☐ Unknown Completed certificate has been si lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an performed?
Yes 2 No **Division of Vital** funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: $_{4\ \square\ \text{Nursing Home}}$ 5 $\square\ \text{Residence}$ 6 $\boxtimes\ \text{Other}$ (Specify) Hospice 1 Tes 2 🖾 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending work?
1 Yes 2 No hours after death Director: And in by the f ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier R143207 12-11-12

TW-5 State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Rd., Rockville, Md. 20855 egistrar's Signatu

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylan	d / Depa	rtment of F	lealth and N	/lental Hygi	iene ₂₀	12	42866
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	<i>Death</i>	Re	g. No.		
	Physicia	n/		1				2. Date of Death Month	Day	Year	3. Time of Death
	Medic	al	Eileen Adele Goulo					December		012	2:00 P ^M
	Examin	er	4a. Facility Name (if not institution, give st	· .	:		Location of Death		4c. County		
			Casey House-Montgor 5. Social Security Number 6. Sex		4 t- (-4t4)	Derwoo If Under 1 Year	If Under 24 Hrs.	Land this	Montg		·
	Funeral Director					Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Coun	place (State or Foreign htry)
			059-20-8269 1 Usual Residence of Decedent	1 N 2 E N 2	36 Yrs.			Dec. 21	, 1925	New	York
and	shov F	5	10a. State 10b. County	10c. Cit	y, Town or Loc	ation				1	10d. Inside City Limits
Aary	Ba-f	ec	Maryland Montgomer	ry M	ontgome	ery Villa	ig e				1 ☐ Yes 2 🛣 No
the	or 2		10e. Street and Number			10f. Zip Code		10	0g. Citizen of V	Vhat Cour	ntry?
with the	s 23a	era	10716 Wayridge Dr:	Lve		2088	66	Ţ	Jnited	State	es
eath	ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	2. Was Decedent Ever in U.S		Vas Decedent of Hi	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No-			can Indian,
الله الله	P	۵	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ♣ No If Yes, Give		Yes 2 No		riidari, etc.j		k, White,	
	tural	Completed by	3 ₺ Widowed 4 □ Divorced	Year or Dates.					Specify:	WI	hite
수 22	edic edic	퉏	15. Decedent's Edu (Specify only highest grad		(Give k		ation Iuring most of work	ing	16b. Kind of Bu	isiness/In	dustry
2	thai	[등	Elementary/Secondary (0-12)	College (1-4 or 5+)	i _	NOT use retired)			Adver	tisi	no
ຊ ທ ອີ	Hygi othe	Be	17. Father's Name (First, Middle, Last)		1 500.	I	18 Mother's Nam	e (First, Middle, M			8
Maryland 21215-0036 2 should be filed within 72 hours after	ental ked ic ev	욘	Francis Quin				Mae Fog	, .			
	nd M		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	a Address (Street a	and Number or Rura	al Route Number.	City or Town. S	tate. Zio (Code)
Σ 5	alth a 27 Is r tra		John L. Gould	(Son)		•	eby Avenu				· 1
e g	of Health and Mental Hygien If item 27 Is marked other th r other traumatic event, the		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of	1	Date 2	20c. Location -		
Page .	nt; If if		1 ☐ Buria! 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metrop	natory or other plac Olitan Htory	e) Dece	mber ₂	Alexand	ria.	Virginia
Baltimore, permit. Page 1 and	Department of Important; If any Injury or once.	М	21. Signature of Funeral		22	Name and Addres	s of Facility De				,,
n 8	8 3 2 2		Ann How	(M00689)	10) East De	er Park l	Drive, Ga	aithers	burg	, MD 20877
			23a. Fart 1 Enter the disease, or compli	cations that caused the deat	h. Do not ente	r the mode of dying	g, such as cardiac o	or respiratory arres	st,		Approximate Interval Between
- Pri	ysician/	6 3	Immediate Cause (Final disease or condition	Anal Ca	ncer					-	Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a consequ							
_	xammei	<u>.</u>	Sequentially list conditions, b							_	
ס	葡	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	uence of):					//	
ecute	g D	×ar	that initiated events cresulting in death) Last	Due to (or as a consequ	ience off:					=1	
50 te be executed	hysician and the buriatmosti	dical	Lossaning in dozial, 2001								
	phys s the	edi									
	ding ase	₹	IF FEMALE: 23b. Was decedent pregnant	sc. If yes, outcome of pregna					23d Dat	te of deliv	erv
Box	after of for u	icla	in the past 12 months? 1 ☐ Yes 2 X No	1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of		Ectopic pregnanc Other (specify)	y		Moi		Day Year
the q	by the achec	Physician/Me	9 Unknown	9 ∐ Unknown							
ords, P.O. Box 687 requires that the death certifica	has been signed by the attending pl ge 2 should be detached for use as t	by P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to th	he cause of death?
dS,	en sig	ed						1 □ Ye	s 2 🕅 No	3 🏻 Pro	bably 4 🗆 Unknown
∵ ≥	as be 2 sho	Completed						24a. Was an autops		Nere auto	psy findings available empletion of cause of
ğ ğ	ate ha page	ĕ						perform	ned?	death?	
<u>a</u> ä	ertific sctor,	Be	25. Was case referred to medical examiner?	10			ace of Death (Chec		ing.		
> ye	his c	욘	I LI fes 2 LFN0	ospital: 1			4 ∐ Nursing Ho	ome 5 🗆 Resider	nce 6 🖾 Othe	r (Specify	Hospice
ב פַּ	After 1 funer	ate	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	? _	28d. Describe how	w injury occurre	∌d	
tend Tend	death	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome form stee		Yes 2 ☐ No	00(1 1: (0)			/B / M
Division of Vital tal or Attending Physician	after Direction of the position of the positio	ခြ	4 Homicide determined	building, etc. (Specify		et, factory, office		28f. Location (Str. City or Town,		er or Hurai	I Houte Number,
Spital	within 24 hours after death. To the Funeral Director: After this certificate har Empletely filled in by the funeral director, page.	edical		ian: To the best of my know							
9F 9F	n 24 ve Fu pletel	Med		er: On the basis of examinatio Practitioner: To the best of r							
5	With a with		29b. Signature and title of certifier	71-1		29c. License	number	29	d. Date signed		
	10		Novah	muler C	RNP	R143	3201		12.	11.	12
			30. Name and address of person who co				D 1 7	1 1	V	1 00	OEE
			Deborah Miller, C				. koad, D	erwood, I	marylan	.a 20	000
	Sta Registra	ie ar	31. Date filed (Month, Day, Year) UEC 1 3 2012	2. Registrar's Signa	pau	Land.					

12-09402 Laura Gooding Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 10, 2012 1135 hrs Medical Examiner Craver Gooding 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street end number) Montgomery Rockville 14635 Bauer Drive Apt. 318 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Maryland Months Days Min Hours Director 02/21/1919 93 577-30-1465 2 × F 1 M Yrs Usual Residence of Decedent 10d. Inside City Limits iny 10a. State 10c. City. Town or Location 1 Yes 2 X No or 28a-f show Rockville s 23a or 28a-f show MD Montgomery hours after death with the Maryland 10e. Street and Number 10f. Zip Code Citizen of What Country United States 20853 14635 Bauer Drive, Apt. 318 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes White 1 Yes 2 X No specify: 3 X Widowed Divorced Yes. Give Yeer Specify 2 16a. Decedent's Usual Occupation (Give kind of work done I6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages 1 and 2 should be filed vithin 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "
injury or other traumatic event, the Medical I MD 21215-0036 Own Home Homemaker 6 0 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mamie Wachter John Gilbert Howes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Cummings Drive, Brunswick, Maryland 21716 Linda L. Marinaro/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Itimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 12/17/12 Rockville, Maryland Parklawn Cemetery 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Roy W. Barber Funeral Home or Laytonsville, Maryland 20882 Box 5038, P.O. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): ner if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death cert ficate be executed Physician/Medical r nding physician a UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Year Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 V Unknown Completed ficate has been s. page 2 should b 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 2 No certificate 1 🗸 the Huspital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital director, Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene After this 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending Director: hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) To the Funeral D determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 11, 2012 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

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			State of Maryland / Depa	artment of Health and M	lental Hygiene	
		_	- State Cer	tificate of Death	Reg. No 2012	42868
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month December 14, 2012	3. Time of Death
	Medic	al	Joanne Burton Gasch 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	December 14, 2012 4c. County of Death	9:45 A M
	Examin	er	Heritage Harbour Health & Rehab Ctr	Annapolis	Anne Aru	ndel
	Funeral	i	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		place (State or Foreign
	Director		257-30-0490 1 □ M 2 🖾 F Yrs.	I I I I I I I I I I I I I I I I I I I	May 21, 1929 Geor	
	and show lat	or	10a. State 10b. County 10c. City, Town or Loc	cation		10d. Inside City Limits
	Maryl 28a-f otified	Director	MD Prince George's Greenbelt	·		Yes 2 No
	th the	al D	10e. Street and Number	10f. Zip Code 20770	10g. Citizen of What Coul USA	ntry?
	ath wi	Funeral	22 Ridge Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13. V			can Indian.
9	or ite	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto		etc.
8	urs af tural" al Exa	ted	3 X Widowed 4 □ Divorced Year or Dates.	Yes 2X No Specify:	Specify: Whit	
5	72 ho n "na Aedic	Completed	(Specify only highest grade completed) (Give i	lent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16b. Kind of Business/In	dustry
21215-0036	within giene. er tha , the I		Elementary/Secondary (0-12) College (1-4 or 5+) Cafet	eria Worker	Schools	
Baltimore, Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) Albert A. Burton	18. Mother's Name Camille	e (First, Middle, Maiden Surname)	
2	d Mer mark matic		-		I Route Number, City or Town, State, Zip	Code
Ma	d 2 shoalth an alth an 27 is		1		tlantic Beach, FL	32233
ore,	of Head of Head fitem rothe		20a. Method of Disposition 20b. Place of Dispo		Date 20c. Location - City or To	own, State
Ē.	Page 1 ment of tant: If it jury or o		4 □ Donation 5 □ Other (Specify) Metro Cr	ematory 12/1	5/2012 Baltimore,	MD
Ball	permit. Page 1 Department of Important: If is any injury or c			. Name and Address of Facility Be . 512 NW $Crain$ Hwy.		
			23a. Part 1. Enter the disease of complications that caused the death. Do not enter			Approximate
1	Physician/	Š.	shock, or heart failure dist only one cause on each time. Immediate Cause (Final disease or condition	Anghi		Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):	74.		
	L Xuminoi	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	ted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury		- 7	
	execu an and urial-tra		that initiated events c. The properties of the control of the con			
9	cate be executed physician and s the burial-transit	Physician/Medical	d			
687	eath certifica attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deliv	verv
Box 68760	leath c atten d for u	iciai	in the past 12 months? 1 Ves 2 Ves 2 Ves 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)	Month	Day Year
P.O.	it the c by the	Phys	9 Unknown	nderhing cause given in Port I	CO- Did to be seen use as while the to to	the angue of Hooth?
٠ <u>,</u>	requires that the der been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the u	indenying cause given in Part i.	23e. Did tobacco use contribute to t	
ord	requii been shouk	Completed			24a. Was an 24b. Were auto	ppsy findings available
Sec.	The law ate has page 2 :	omp			autopsy prior to co performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes	ompletion of cause of
a	sician: The certificate irector, paç	Be C	25. Was case referred to medical examiner?	26. Place of Death (Check		
\equiv	Physic this ce al dire	욘	1 Yes 2 Hospital:		me 5 Residence 6 Other (Specif	y)
0 U	ding F th. After funer	cate	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
Division of Vital Records,	Atten er dear ector: by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined building, etc. (Specify)		28f. Location (Street and Number or Rura City or Town, State)	ll Route Number,
<u>S</u>	Phospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice etely filled in by the funeral director,					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier (Check Check only one) 3 ☐ Certifying Physicial: To the best of my knowledge, death (Check only one) 3 ☐ Certifying Nurse Physittioner: To the best of my knowledge	tigation, in my opinion, death occurred a	t the time, date and place, and due to the ca	ause(s) and manner stated.
	To the within To the comple	Σ	only one) 3 Certifying Nurse Phycitioner: To the best of my knowledge 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month,	
D				1057028	Daember	14/2012
	400		30. Name and address of person who completed cause of death atem 23a) (Type, F	au Se 231 A	mapolis (MD) 2	041
	Stat Registra		31. Date filed (Month, Day, Year) 7 2012 32. Registrar's Signature	backer		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Waryland	•	tificate of l		Re		2 42869
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ralph Edward					2. Date of Death		3. Time of Death 12 1844 M
	Examin	er	4a. Facility Name (if not institution, give si Vindobona Nursin	g Home		Fred	r Location of Death erick		4c. County of Freder	
	Funeral Director		5. Social Security Number 214-14-6185 Usual Residence of Decedent	7. Age (<i>In yrs. Ia</i> : M 2 🗆 F	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Aug • 31,	Yearl o o o	. Birthplace (State or Foreign Country) Mary Land
	Aaryland 8a-f show	Director	10a. State 10b. County Maryland Frederic		Town or Located					10d. Inside City Limits 1 ☐ Yes 2 ☒️No
	s 23a or 2	Funeral Di	10e. Street and Number 4716 Teen Barnes	Road		10f. Zip Code 217()3	10	0g. Citizen of Wha	
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other then "naturely", or items 28a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be rediffed at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1₹☐ Yes 2 ☐ No If Yes, Give Year or Dates.1943-1	.945	Yes, specify Cub		ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
Baltimore, Maryland 21215-0036	within 72 ho giene. er then "nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give I life. DC	lent's Usual Occup kind of work done O NOT use retired tal Cleri	during most of worl	ing	16b. Kind of Busin US Posta	al Service
yland	id be filed v Mental Hyg arked oth atic event,	To Be	17. Father's Name <i>(First, Middle, Last)</i> Raymond Lewis	Goodsell				ne (First, Middle, M. Viola Be		
, Mar	nd 2 shoul ealth and m 27 is m		19a. Informant's Name/Relationship <i>(Typ</i> Mrs. Sandra R. Boy	wman, Niece	8400	Bowman 1	and Number or Rur Farm Road			
timore	t. Pege 1 e tment of H tant: If ite jury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State St	emetery, cren LUK		tery Dec.	24, 2012		rick, MD
Bal	permit Depart Impor any In		21. Signature of Funeral Service License	M0025	55 K	. Name and Addre .eeney an 06 East	s of Facility. d Basford Church St	l PA Fune Frede	ral Home rick, MD	21701
	Trysician/ Medical Examiner		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on soch line.	nsiv	VI SHOW THE	ng, such as cardiac		isease	Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any losoing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a conseque	ence of):					
3760	ificete be executed g physician and as the burlal-transit	Medical Ex	resulting in death) Last	Due to (or as a consequent.	ence of):					
Division of Vital Records, P.O. Box 687	death cert	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnan Other (specify)	су		23d. Date of Month	· ·
ds, P.0	luires that to en signed by uld be deta		Part II. Other significant conditions cor	itributing to death but not resu	ulting in the u	nderlying cause g	ven in Part I.		1 .	ite to the cause of death?
Recor	To the Hospital or Attending Physicien: The law requires that the within 42 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Completed						24a. Was an autopsy perform	prio ned?, dea	re autopsy findings available or to completion of cause of th? Yes 20 No
<u>ta</u>	siclen: certific rector,	Be	25. Was case referred to medical examiner?	lospital:		- Tou	lace of Death (Chec	k only one)		
n of V	nding Phys tth. : After this e funeral di	cate: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending Accident Investigation	1 ☐ Inpatient 2 ☐ I	ER/Outpatien 28b. Time of injury	at 3 LJ DOA 28c. Inju	y at Nursing H	ome 5 Resider 28d. Describe hov		Specify)
Divisio	tal or Atter s after dea al Director ed in by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre			28f. Location (Str. City or Town,		or Rural Route Number,
	the Hospit nin 24 hour the Funera npletely fill	Medical	(Check 2 Medical Examinonly one) 3 Certifying Nurse	cian: To the best of my knowle er: On the basis of examination Practitioner: To the best of m	and/or invest	tigation, in my opini	on, death occurred a	it the time, date and	place, and due to	the cause(s) and manner stated.
	6		29b. Signature and title of certifier	Laufman		29c. Licens	e number 1397/		December	Month, Day, Year) - 20, 2012
	8 lu		30. Name and address of person who co Robert L. Kaufma	nn, M.D., 300	West	Ninth St	reet, Fre	derick,	MD 21701	
	Stat Registra		31. Date filed (Month, Day, Year) JAN 0 4 2013	32. Registrar's Signatu	face	~				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 15 2012 Lois Smith Harrison 15:30 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12835 Fountainhead Rd. Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🗓 F Hours May 13, 1924 218-38-2171 88 Marvland **Director** Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Washington Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12835 Fountainhead Rd. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 X Widowed 4 □ Divorced Year or Dates intal Hygiene. ked other than "natura c event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Personal Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ည permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Richard Paul Smith Henrietta Menges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Harrison-son 12835 Fountainhead Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Rest Haven Cemetery 12-22-2012 1 X Burial 2 Cremation 3 Removal from State Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home e of Funeral Service License 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Parkinson's Disease Unlenous disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, iner Due to (or as a consequence of) if any, leading to immediate Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Amal Fibrillation 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension autopsy Dysphagia 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State

22911

egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M Coheen

31. Date filed (Month, Day, Year

D0071052

Jefferson Blud Smithsburg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10e per FH FCHD TM 12/13/12
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:20 A^{M} LEE HITESHEW December 2012 SANDRA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Director 212-50-9609 1 □ M 2 🖾 F 64 9. 1948 MD Jan. 10c. City, Town or Location 10a. State or then "neturel", or items 23e or 28e-f eho the Medical Examinar must be notified at 10d. Inside City Limits filed within 72 hours efter death with the Meryland Director 1X Yes 2 ☐ No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Unit Funeral 2520 Waterside Dr. - Unite 21701 USA 307 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. ۾ 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Completed Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I end 2 should be fil f Health end Mentel item 27 ie merked ည Robert Slagle Betty Mackley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip Greg Hiteshew/husband 2520 Waterside Dr.,Unit 307, Frederick, MD 21701 saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Depertment of I Important: If it eny injury or of Pege 1 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 12/12/12 Stauffer Crematory Frederick, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ancrea NONTH Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ettending physicien end I for use as the burief-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical a Hospitel or Attending Physicien: The lew requires that the deeth certificate be a 24 hours after deeth.
24 hours after deeth.
Funerel Director: After this certificate has been eigned by the ettending physiciel letely filled in by the funeral director, page 2 should be deteched for use as the bure letely filled in by the funeral director, page 2 should be deteched for use as the bure Records, P.O. Box 68760 IF FEMALE: f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 2 No 1 ≥ Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be To the Hospitel or Atterwithin 24 hours after devented to the Funeral Director completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1, 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10g per FH FCHD TM 12/13/12
State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:30 PM 2012 David G. Holt December Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Citizens Care & Rehabilitation If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 439-48-5373 1 M 2 □ F 77 July 31,1935 Texas show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours efter death with the Maryland ir then "natural", or items 23e or 28a-f sho the Medical Examinar must be notified at Director Ijamsville 1 🗆 Yes 2 🗓 No Frederick Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21754 Funeral 9814 Mahogany Run YSA USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give V Year or Dates. ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Vietnam Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
Inventory Control (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Government Be permit. Pege 1 end 2 should be filed Depertment of Heelth end Mentel Hy Important: If item 27 is merked oth any injury or other traumatic event <u>once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Holt Lutie Hogue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9814 Mahogany Run, Ijamsville, MD 21754 Yaeko Holt / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Stauffer Funeral Home Signature of Funeral Service Lice 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onget and Death Immediate Cause (Final P-515 Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine anding physician end use as the burial-transit The lew requires that the death certificate be executed Cause (Disease or in that initiated events Due to (or as a consequence of): resulting in death) Last ettending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day n signed by the et uld be detached fo Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed To the Hospitel or Attending Physician: The lew requires within 24 hours efter death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Ø No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? 1 ☐ Yes 2 ☐ No М Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatur nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 UZ2 12/11/12 30. Name and address of person why completed cause of death (Item 23a) (Type, Print)

1. AUFEN BOLAWN, 196 TIPLUE, FLERE EICE, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2012 Registrar

12-09767 James Henson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death
Reg. No.

		1- For State Registrar	Certificate o	of Death	R	eg. No.	
Physici	an/	Decedent's Name (First, Middle,Last)			2. Date of Dea Month	Day Year	3. Time of Death 1829 hrs
Medical Exami	ner	James Henson 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location		r 22, 2012	
		Baltimore Washignton Medical Center		Glen Burnie	or Death	Anne Arunde	
Funeral		5. Social Security Number 6. Sex 7. Age (In y	yrs. last birthday)	If Under 1 Year If Und	er 24Hrs. 8. Date of Bi	rth(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		214-56-0525 1XM 2_F	65 Y	rs. Months Days Hours	s Min. Sept 2	27 1947 Tore	gn Wannyland
		Usual Residence of Decedent			·		
w any			City, Town or Loc				10d. Inside City Limits 1 Yes 2 No
Maryland 28a-f show d at once.	ģ	Maryland Anne Arundel	Odento			0g. Citizen of What Co	
e Mar or 28a	Director	650 Old Waugh Chapel Rd.		10f. Zip Code 21113		USA	and y?
i with the Maryland ms 23a or 28a-f sho be notified at once.		11. Marital Status 12. Was Decedent Ever	in II S I 13 V	Vas Decedent of Hispanic Ori	gin? (Specify Yes or No		rican Indian, Black,
eath w	Funeral	1 X Never Married 2 Married Armed Forces?	if	Yes, specify Cuban, Mexicar		White, etc.	Trock (Figure, States,
after d ul", or ner. m	by Fi	3 Widowed 4 Divorced If see, Give Year or Dates:	1	Yes 2 X No specify		Specify:	31ack
nours :	8	15. Decedent's Education (Specify only highest grade complete		ent's Usual Occupation (Give most of working life. DO NOT		16b. Kind of Business	/Industry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12th O	1	spector	,	Nevamar Plastic	Plant
-00. I with giene	E	17. Father's Name (First, Middle, Last)			r's Name (First, Middle,		
215 of file stal Hy ked o	Be	William Henson			herine Ha		
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 127 is marked other than "natural", or items 23a or 28a-f shoumatic event, the Medical Examiner, must be notified at once		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Nur			
nore, MD 21215-00 ages I and 2 should be filed wit nt of Health and Mental Hygien it: If item 27 is marked other other traumatic event, the M.		Walter Henson(Brother)		Old Waugh C			
of Her tr		1 Burial 2 X Cremation 3 Removal from State	crematory or o	' '	Date	20c. Location - City o	
Baltimore, permit. Pages I at Department of He important: If ite niury or other tr	١	t Dendret e Journet epochy.				Baltimo	
Baltimo permit. Page: Department o Important:		21. Signature of Funeral Service Licensee	22 V	Ware and Address of Facilit 1922 Forest	Sons Mort	uary, P.A	1.
Physician	12 29	23a. Part I. Enter the disease, or complications that caused the de					21401 Approximate Interval
/Medical	5 (failure. List only one cause on each line.					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) AHYPETENSIVE Due to (or as a consequence)		terotic cardi	ovascular 1	Olsease	
	L	Sequentially list conditions, b.	-6				
	Examiner	if any leading to immediate Due to for as a consequent cause. Enter Underlying Cause C.	ce (II).				
git q	, al	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequent	ce of):				
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760, Icate be e physicia the burial	Medical	IF FEMALE: 23c. If yes, outcome of p		лет ше, дэээ т	7 13 3m	23d. Date of deliver	
1876 rtifical ing ph	- 1	23b. Was decedent pregnant in the past 12 months?		Fetal death 3 Ectopi	c pregnancy	and the second second	Day Year
Box 687 death certificate at the attending	sici	4 Pregnant at time of	of death 5 (Other (Specify)			
O. B.	Physician	Part ii. Other significant conditions contributing to death but n	not resulting in the	underlying cause given in Pa	art I. 23e, Did t	obacco use contribute to	the cause of death?
F. P.O.	<u>ā</u>	Diabetes Mellitus		, , ,	1 Ye	s 2 No 3 Pro	bably 4 🗸 Unknown
ds, require	Completed				24a. Was		utopsy findings available
e law e has l	ם					rmed? death?	completion of cause of
Vital Rec ysician: The his certificate director, page		25. Was case referred to medical		26.Place of Death	1 ✓ Yes (Check only one)	2 No 1 Y	es 2 No
of Vital Records, og Physician: The law requir of the certificate has been so meral director, page 2 should t	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatier			Residence 6 Othe	er:
ding Ph		27. Manner of Death 28a. Date of Injury	28b. Time of			how injury occurred	
ttendi death. rtor:	랿	2 Accident Investigation		1 Yes 2			
Division pital or Attendir ours after death.	ertification:	Suicide Could not be	At home, farm, str	eet, factory, office building, e	tc. 28f. Location (or Town, S	Street and Number or R State)	ural Route Number, City
ospita hours uoeral	ပ	29a. Certifier	uladga dagth see	umad at the time, date and al	and due to the saw	co(o) and manner of sta	and .
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one) 2 Medical Examiner: On the basis of examination					
To cor	ě	and manner stated. 29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo	onth, Day, Year)
		Alla buillette		O.C.M.E.		December 23, 2	012
_		30. Name and address of person who completed cause of death (Item 23a)	1		<u> </u>	
		Melissa Brassell, MD Assistant Medical Exa		W. Baltimore Street, B	altimore, MD 212	23	
Si Regis	ate	31. Date filed (Month, Day, Year) 32. Registrar's Sig		racked			
Regis	للثات	THE UN LUID CHANGE	100 160	State and			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? [] | 2 42874 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death becember Day 3 2012 0410 Mildred D. Holliday 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Annapolis 8. Date of Birth (Month, Day, Year) Feb 2 1934 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Days 216-30-5571 1 □ M 2**X** F Maryland 78 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 X No Annapolis Mary1and Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe USA 21401 111 Dominoe Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 X No 1 Yes 2 If Yes, Give 1 ☐ Yes 2X No Specify: Black Specify: 3 ☐ Widowed 4X Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Anne Arundel Co. College (1-4 or 5+) 6+ Elementary/Secondary (0-12) 12th Public Schools Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lelia White Henry E. Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21403 3237 Henson Ave Cecilia Derrick(Daughter) 20c. Location - City or Town, State 20a. Method of Disposition Date 20b. Hape of Disposition (N 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 12-18-12 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) W Marre a Recessor Facility Sons Mortuary, P.A. 21. Signature of Funeral Service Licenses 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Onset and Death Immediate Cause (Final

Physician/ Medical Examiner

attending physician a for use as the burial-

signed by

Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director; After this certificate has b

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

permit. Page 1 a Department of H Important: If ite any injury or of

Physician/

Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho: other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine Physician/Medical ρ Completed To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, Certificate:

29a. Certifier

(Check

only one 29b. Signature

31. Date filed (Month

Certifying Nurse

disease or condition resulting in death)	a. Due to (or as a consequence of):		-
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	L. Nonalchelic Steatchepar Due to (or as a consequence of):	Libs.	
resulting in death) Last	Due to (or as a consequence of): d		_
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year	
Part II. Other significant conditions	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	
		24a. Was an autopsy performed? 1	ole of
25. Was case referred to medical	26. Place of Death (C	Check only one)	
examiner? 1 🗌 Yes 2 🔀 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin	g Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could no		28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	1 220 Place of Injuny - At home form street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)	

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 06-2011

Registrar

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year William Albert Honaker 04:00 PM December 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 49 Pinder Avenue E1kton Ceci1 Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days Hours Director 1 D M 2 D F 218-70-2840 55 Dec. 17, 1957 Maryland parmit. Pega 1 end 2 should ba filed within 72 hours aftar daath with tha Maryland Depertment of Haalth and Mental Hygiana. Important: if item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Est infiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Mary land Ceci1 E1kton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 49 Pinder Avenue United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. é 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Diesel Truck Mechanic Truck Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Carl Albert Honaker Dorothy Evelyn Isaacs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Kyle / Companion 49 Pinder Avenue, Elkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ebenezer Cemetery 20, 2012 Rising Sun, Maryland 21. Signature of Juneral Serv 22. Name and Address of FacilityCrouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated expenses.) Examiner Due to (or as a consequence of) signad by the attanding physician and id ba detachad for usa as tha burlei-transit To the Hospitei or Attanding Physicien: Tha law raquiras that tha death certificate ba axacutad within 24 hours aftar death.

To tha Funeral Director: After this cartificata has baan signad by the attanding physician and complataly filled in by the Attanding complataly filled in by the Attanding complataly filled in by the Attanded to the second attanding the Complataly filled in by the Attanded to the Complataly filled to the Attanded to the that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this cartificata has baan sk a funaral diractor, paga 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nuyse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, 5 D0062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ XHAN MD AUGUSTINE HERMANHWY, SUITEA, CHESAPEAKE CITY 31. Date filed (Month, Day Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 42876 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 18 2012 06:05 PM Carolyn J. Hildebrand Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ceci1 Elkton Care and Rehab E1kton If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, June 9, 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Days Months Hours ^Y1911 Mary Land **Director** Yrs. 217-12-5230 101 Usual Residence of Decedent 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 ☐ No Maryland| Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1 Price Drive 21921 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc 1 Never Married 2 Married <u>Ş</u> Maryland 21215-0036 If Yes, Give Year or Dates White 1 ☐ Yes 2 XXNo Specify 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other trainmetic. Elementary/Seconday (0-12) College (1-4 or 5+) Switchboard Operator Telephone Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles W. Armiger Carrie Lanhan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27527 Carolyn Howard / Daughter 293 Stansbury Lane, Clayton, North Carolina Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State December 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 19, 2012 Newark, Delaware 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ch conic Kulmonary Unkning. Physician/ Obstructive disease or condition Medical resulting in death) Examiner Sequentially list conditions Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Examin requires that the death certificate be executed Cause (Disease or iinjury that initiated events and trar resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Unknown the the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of or Attending Physician: The law s certificate has t lirector, page 2 s autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fur 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

within 24 hor To the Fune completed fi

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. S. Sachdev MD, 126 4 E High ST,

sachders MD

3 [

29b. Signature and tip of certifier

126 AE High ST

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

00023322

29d. Date signed (Month, Day, Year,

12.19.2012

AMEND ITEM 0 ...
12/26/2012 PER FHor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene

,			
	Certificate	of i	Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 No

12:15A M

Physici /Medio		1. Decedent's Name (First, Middle Gieorge	w Hou	vell			2 Date of Death Month December	18 2012	3. Time of Death 12:15A
		Morningside Ho	use Assisted	Living				4c. County of Death	arles
		210 21 3/23	6. Sex 7. Aga 1 M 2 ☐ F		Months Da	ear If Under 24 Hrs. Lys Hours Min.	8. Date of Birth Feb. 2, 19 Feb. 2, 19		nplace (State or Forei untry) cyland
and show	ctor	10a. State 10b. County	Mary's			all			10d. Inside City Limit
s 23a or 28 nust be cu	eral Dire			Funcia II C		20622		USA	A
rat', or Item Exerciter:	þ		Armed Forces?	No			ecry Yes or No- Rican, etc.)	Black, White	
ene. then "natu he Mudical	ompletec	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)	(C	Give kind of work do fe. DO NOT use re	one during most of work tired)	aing 16		,
uld be filed Aental Hygi rked other tic event,	Be					18. Mother's Nam		iden Sumame)	
ealth and h		Wanda L. Pingito		1220	00 Peabod	y Lane Chai	rlotte Ha		
tment of H tant: If Iter jury or oth		1 XBurial 2 ☐ Cremation 4 ☐ Domation 5 ☐ Other (Se	ociby		ll Cemete	ry Dec.	22,2012 H	agerstown,	Maryland
Deper Impor any in once.		(inl	A		425 S. Co	nococheague	e St.Will	iamsport,M	ID 21795
		23a. Part 1. Enterthe disease, or shock, or heart ailure. List of limmediate Cause (Final disease or condition resulting in death)	a	Pali	mona	ly em	holi sh	n	Approximate Interval Between Onset and Death
The second	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	onsequence of):	the t	teoul-	Foilor	۴	
by the attending phys stached for use as the	hysician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth	2 Fetal death				23d. Date of delifing Month	very Day Year
	Ithent of Health and Mental Hygiene. Franct: If Item 27 is marked other then "natural", or Items 23a or 28a-f e-how france or other traumatic event, the Medical Exporter most be motified at a high property or other traumatic event, the Medical Exporter most be motified at a high property or other traumatic event, the Medical Exporter most be motified at a part of the motified at	Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturat", or Items 23a or 28a-1 ehow any Injury or other traumatic event, the Modical Exercitive most be notified at any Injury or other traumatic event, the Modical Exercitive most be notified at any Injury or other traumatic event, the Modical Exercitive most be not any Injury or other traumatic event, the Modical Exercitive and Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event, the Modical Exercitive at any Injury or other traumatic event	Medical Examiner 4a. Facility Name (If not institution, Morningside Howard Independent of Decedent 10a. State 10b. County 10b. County 10a. State 10b. County 10b. County 10a. State 10b. County 10b.	Medical Examiner 4a. Facility Name (If not in) titution, give street and number) Morningside House Assisted	Medical Examiner Morningside House Assisted Living	Medical Examiner Morningside House Assisted Living Wal Morningside House Assisted Living Wal S. Social Security Number 213-24-9729 S. Social Security Number S. Social Security Number S. Social Security Number S. Social Security Number 213-24-9729 S. Social Security Number S. Social Security Numb	A	As Facility Name (If not usalitution, give street and number) As Facility Name (If not usalitution, give street and number) As Facility Name (If not usalitution, give street and number) As Facility Name (If not usalitution, give street and number) As Facility Name (If not usalitution, give street and number) As Facility Name (If not usalitution) Facility Name (If not usalitution) As Facility Name (If not usalitution) Facility Na	Ab City, Town, or Location of Death Ab City, Town, or Location of Death Ab County of Death Ab City, Town, or Location Ab City, Town, State, It Ab City, Town

Division of Vital Records, P.O. certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Completed by

Be

Medical

Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown

24a. Was an autopsy performen? Yes 2 10 1□ Yes 26. Place of Death | Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 X o

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation 6 Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year)

3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Matural

2 Accident

3 Suicide

4 Homicide

Certifying Physician: To the best of my knowledge daeth unumer at the time, date and class and due to the nause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death f death (Item 23a) (Type Awation Blud, steB, Gren Busnic, mD

State Registrar

31. Date filed (Meeth

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gregory Joseph Hobbs Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) Physician/ 1501 hrs Medical Examiner Gregory Joseph Hobbs December 18, 2012 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Elkton Cecil Union Hospital 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Delaware Months Davs Hours Director 01/15/1963 1 X M 2 F 49 221-52-2629 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location in 10b. County 1 Yes 2 X No or 28a-f show s 23a or 28a-f show Elkton Pages I and 2 should be filed within 72 hours after death with the Maryland nen to Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f she ro other traumatic event, the Medic all Examiner must be notified at once Ceci1 Maryland irector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 339 Willow Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1 X Yes If Yes, Give Year 1 Yes 2 X No specify: Specify: 3 Widowed 4 Divorced White δ Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 Night Auditor Hote1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Shields James F. Hobbs, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other traumatic Nina Marie Hobbs/Wife 339 Willow Drive, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State December crematory or other place) 1 Burial 2 X Cremation 3 Removal from State tment or 20, 2012 West Chester, PA 4 Donation 5 Other Specify. A. Ferris & Co., Inc. 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Six ature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD Approximate Interval is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complication **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical sician UNPENDED AMENDED burial Division of Vital Records, P.O. Box 68760, 23d. Date of deliver attending phys or use as the bi 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Other₄ Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Certification 1 V Natural 1 Yes 2 No Director: 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be Suicide determined Homicide 29a. Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier December 19, 2012 O.C.M.E. 30/ Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Pamela E. Southall, MD 32. Registrar's Signature State Registra

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		1- For State Registrar		Certifi	cate of De	ath		R	eg. No.		
Physici	an/	1. Decedent's Name (First, Middle	e,Last)		_			Date of Dea Month	th Day	Year	3. Time of Death
<u>ledical Exami</u>	ner	DAVID LAMO	NT HARL	EY				Decembe	r 13, 2	012	1244 hrs
		4a. Facility Name (if not institution	n, give street and number)	4b. Cit	y, Town, or	Location of Death		4c.	County of Death	1
		Baltimore Washington	Medical Center		Gle	en Burnie			A	nne Arundel	
Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last b	oirthday) If U	Inder 1 Year	If Under 24Hrs	. 8. Date of Bi	th (MM/D		thplace (State or
Director		212 02 1066	1X M 2 F	45	Yrs. Mo	nths Days	Hours Min.	GED 10	100	Foreig	untry)
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any		10a, State 10b. County	-	10c. City, Tov	vn or Location						10d. Inside City Limits
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Maryland 28a-f show d at once.	햧	MD ANNE A 10e, Street and Number	KUNDEL	SEVERN		Zip Code		11	Oa Citiz	en of What Cou	ntry?
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after iner	á		orced If Yes, Give Year or Dates:			2K No				Specify: AMER	
hours : "natura Exami	b	15. Decedent's Education (Spec			a. Decedent's Usu during most of		ion (Give kind of v DO NOT use reti		16b. K	ind of Business/	Industry
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Ker er sithir	Completed	12		D	ELI CLER					CERY ST	'ORE
15-003(filed within I Hygiene. of other tha		17. Father's Name (First, Middle,				1	18.Mother's Name			,	
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be	JAMES MELVIN						ILLIAN			
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and 2 shorters ten 27 is traumatic		RANAYE HARLEY/S	ISTER		5905 BUM	PY OA	K ROAD,L	A PLATA	MAR	RYLAND 2	0646
imore, MD 21215-0036 Pages I and 2 should be filed within 72 men of Health and Mental Hygiene. Tant: If item 27 is marked other than or other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 X Cremation	3 Demoval from St		e of Disposition (I		netery,	Date	20c. L	ocation - City or	Town, State
TOF		4 Donation 5 Other Sp.			NTIC CRE	MATOR	y 12/	17/2012	GLE	N BURNI	E. MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other th		21 Signature of Funeral Service					of Facility RAY	MOND FU	NERA	L SERVI	CE.P.A.
E E E		for Bal	T See	M0064			NGTON AV				
Physician		23a. Part I. Enter the disease, or				de of dying,	such as cardiac o	r respiratory arr	est, sho	ck, or heart	Approximate Interval
/Medical	S 16	failure. List only one cause of Immediate Cause (Final disease	a. Asphyxia								Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cons	equence of):							
		Sequentially list conditions,	b								
	ē	if any, leading to immediate	Due to (or as a cons	equence of):							
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	equence of):					_		
red nsit	Ä	events resulting in death) Last	•	equerice or).							
ox 68760, ant certificate be executed attending physician and or use as the burial - transit	g	UNPENDED	dAMENDED								
	ğ								Land		
376 ficate g phy s the	١₹	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnanc	cy 2 Fetal dea	eth 3	Ectopic pregna	incv		Date of deliver. Month	/ Day Year
c 68 certi endin use a	<u>cia</u>	past 12 months?		t time of death	5 Other (S			,			
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medi	1 Yes 2 No 9 Unk	nown 9 Unknown			, ,,			Ť		
		Part II. Other significant conditi	ons contributing to deal	ih but not result	ting in the underly	ing cause g	iven in Part I.	23e. Did to	obacco u	se contribute to	the cause of death?
P.O. es that the iigned by be detach	d b							1 Ye	s 2 🗸	No 3 Proi	pably 4 Unknown
cords, P. Iaw requires the has been signed 2 should be designed.	Completed							24a. Was			topsy findings available
CO law i has t	g								rmed?	death?	completion of cause of
zal Rec inn: The l certificate l	હ							1 ✔ Yes	2 No	1 Y	es 2 No
Vital ysician: his certifi director,	B	25. Was case referred to medical examiner?	Hospital:			. 1	of Death (Check of Other, Nursin				
Division of Vital Records, tal or Attending Physician: The law requirers after death. 11 Director: After this certificate has been siled in by the funeral director, page 2 should be	은	1 ✓ Yes 2 No	Hospital: 1 Inpati		/Outpatient 3] 5 3 11		g Home 5			
n of \ding Ph.		27. Manner of Death 1 Natural 5 Pand	28a. Date of Inj (Month, Day, Dec 6, 2012	ury Year) 280	b. Time of Injury 35 hrs		yatWork? ′es 2 ✔ No	28d. Describe Subject ass			
Sior Attend r death. ector; by the	atic		tigation								
ivisior or Attene after death Director; I in by the	ij		not be	njury - At home,	, farm, street, fact	ory, office b	·	or Town, S	State)		ral Route Number, City
Divis the Hospital or A hin 24 hours after of the Funeral Direc npletely filled in by	Certification:	4 Momicide	mined (Specify) Sig	dewalk				8035 Fair Bre	eze Dri	ve, Severn, M	D
the Hospital hin 24 hours the Funeral		29a. Certifier 1 Certifying Ph	ysician: To the best of n	ny knowledge, d	death occurred at	the time, da	ite and place, and	due to the caus	se(s) and	manner as stat	ed.
To the Hos within 24 h To the Fur completely	Medical		niner:On the basis of exa	amination and/o				it the time, date			
	ž	29b. Signature and title of certifier	r	, //		29c. License			1	ate signed (Mo	
		10/11-1	ell	/		O.C.N	M.E.		Dece	ember 14, 20	012
6 pm		30. Name and address of person							•		
- A.	9 8	Zabiullah Ali, M.D.	Assistant Medical E	xaminer 9	900 W. Baltim	ore Stree	et, Baltimore,	MD 21223			
9	ate	31. Date filed (Month, Day, Year)	22 Registra	ar's Signature				-			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend 20a per FD, Registrar DOR, 12/13/12, LDE Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ nnet Igene Medical 4a. Facility Name of not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Apt. Crusad Dorches ambrid Social Security Number If Under 1 Year | If Under 24 Firs 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** 7. Age (In yrs. last birthday) 1 M 2 F Months Hours 66-80 **Director** Pennsylvania TAN. 28a-f show 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No ō 10e. Street and Numbe 10g. Citizen of What Country? 23a 303C items 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Completed by "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Black Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Musical Instruments er-Vice Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 hristi am Dorsey 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important; If it
any injury or o cemetery, crematory or other place)
Mid Shove Crematics Ch Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cambridge, 21. Signature of Funeral Service Licenses 22. Name and Iddress of Facility Henry, Funeral Home, P. A. ington str Cambridge 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. or respiratory arrest. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ MUSCARDIAL INFARCTION IMMEDIATE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant:
9 Unknown in the past 12 months?
1 Yes 2 No for Month Day Pregnant at time of death ned by the al 9 Unknown P.O. sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown MORBID OBESITU Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 \(\sum \) No death? this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\times \) Residence 6 \(\sum \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work?
1 Yes 2 No 5 Pending iniury Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 DO070752 DEC 11, 2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROHAN BYRN STREET, CAMBRIDGE, MD 21613

DHMH 17 Rev 7/2009

State Registrar MOFFATT

31. Date filed (Month, Day, Year)

503

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER Day Physician/ INGRAM Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. **Funeral** Director 219-46-3142 1 M 2 X F 66 3, 1946 Maryland Mar. 28a-f shov 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No Hagerstown Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 423 Wyoming Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Supervisor of Housekeeping Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important if item 27 is marked any injury or other traumatic once. ည Virginia Isabelle Eichelberger Charles Henry Heiston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald A. Ingram/Son 423 Wyoming Ave., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 12/22/2012 Hagerstown, MD Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Rest Haven Funeral Chapel 22. Name and Address of Facility 21742 1601 Pennsylvania Ave., Hagerstown, MD Part 1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1, Enter the disease, or co Approximate Interval Between Onset and Death Immediate Cause (Final Bowel Physician/ ischemi disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) Day Year 1 Yes 2 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 № No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗹 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 DECEMBER 172012

5

Registrar
DHMH 17 Rev 06-2011

State

1800 ORLEANS ST BALTIMORE MD 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12-09477 Joseph Louis Johnson, III

-09477	Please Type	or Print in Black Inde	lible lnk. Ensure All C	opies Are Leg	ible. 2012	42882
seph Louis John	1- For State		nent of Health and Ment cate of Death		. N o.	
Physician edical Examine				2. Date of Death Month December		3. Time of Death 2136 hrs
>	4a. Facility Name (if not institution, s		4b. City, Town, or Location of Annapolis		4c. County of Death Anne Arundel	
Funeral Director		Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 3 3 Yrs. Months Days Hours		(MM/DD/YYYY) 9. Birth Foreign 5 1979 Mu	place (State or numyland
w any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location timore			10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	Maryland N/A	Ват	10f. Zip Code	100	g. Citizen of What Count	
r death with the h or items 23s or must be notifie		12. Was Decedent Ever in U.S. Armed Forces?	21225 13. Was Decedent of Hispanic Original of Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)	USA 14. Race - Americ White, etc.	an Indian, Black,
s after deatl		1 Yes 2 No	1 Yes 2 X No specify:	_	Specify: B1 a	
5-0036 led within 72 hours after details, after than "natural", the Medical Examiner Commissed by		College (1-4 or 5+)	during most of working life, DO NOT	use retired)	Wendy's Re	
21215-0036 July be filed within 72 hours after death with the Maryland formel Byggiers, or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at once To Re Commissed by Firmeral Director				's Name (First, Middle, Ma n Callowa		
Baltimore, MD 21215. permit. Pages 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the	19a. Informant's Name/Relationship Joseph L. Joh	nson Jr(Father	9b. Mailing Address (Street and Num) 4022 6th St.	Baltimore	, Md. 212	25
Baltimore, oemit. Pages 1 and Department of Heal Important: If iten injury or other tra	20a, Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spec	Memo	e of Pispostion Name of cemetery, latory or other place) Orial Gardens	Date 12-20-12	20c. Location - City or 1 Annapoli	
Baltir permit. 1 Departm Imports injury o	21. Signature of Funeral Service Lie	ensee	27W Hame and Address of Facility 1922 Forest	Dr. Annap	olis, Md.	21401
Physician Wedital Examiner	failure. List only one cause or Immediate Cause (Final disease		not enter the mode of dying, such as o	ardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
	or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of): b. Due to (or as a consequence of):				
		c. Due to (or as a consequence of):				
50, te be executed ysician and burial - transit	UNPENDED	d				
x 6876 h certifical tending ph	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 Live birth 4 Pregnant at time of death	2 Fetal death 3 Ectopi	c pregnancy	23d. Date of delivery Month D	ay Year
P.O. BO:	ŝ	9 Olikilowii	ting in the underlying cause given in P		pacco use contribute to t	
Records, P The law requires t ficate has been sign , page 2 should be c				24a. Was a autops perform	y prior to coned? death?	opsy findings available ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requints after death. Tal Director: After this certificate has been so and in by the funeral director, page 2 should the first of the first of the first director.	examiner?	Hospital: 1 Inpatient 2 ER	26.Place of Death			
Sion of Vi Attending Physi death. extor: After this by the funeral di		g Dec 12, 2012 21	b. Time of Injury 28c. Injury at Worl 119 hrs 1 Yes 2	No Subject shot		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	3 Suicide 6 Could 4 Homicide	28e. Place of Injury - At home ined (Specify) Townhouse /		or Town, St 1458 Tyler Ave	enue, Annapolis, MD	
To the Hospital within 24 hours To the Funeral completely filled	_ Z3a. Columbia Cartifuing Phy	sician: To the best of my knowledge, iner:On the basis of examination and/o and manner stated.	death occurred at the time, date and pi or investigation, in my opinion, death o	ccurred at the time, date a	and place, and due to the	e cause(s)
	Allens	Brouge At	29c. License number		29d. Date signed (Mor	
5/1g	Melissa Brassell, MD		900 W. Baltimore Street, E	Baltimore, MD 2122	3	
State Registra		2012 32. Registrar's Signature	A. Sall			

JCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Rence Month 5:05AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 306 Phelps Avenue Glen Burnie If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min. Director 219-34-1124 1 X M 2 □ F 74 Maryland May 13, 1938 or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director Anne Arundel Glen Burnie 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? Funeral 306 Phelps Avenue 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Namied X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 X No Specify. White 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Communications & other than Elementary/Secondary (0-12) College (1-4 or 5+) Signals 12 Operations Inspector permit. Page 1 and 2 should be filed w Depertment of Health and Mental Hygi Important: if item 27 Is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Norma B. Gilchrest Charles W. Jahns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores A. Jahns / Wife 306 Phelps Avenue Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) December 14 Metro Crematory, INC. Baltimore, MD 2012 21. Signature of Funeral Service Lice 22. Name and Address of Facility P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, of heart failure. List only one cause on each line. Approximate terval Between Physician/ UNG sease condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed signed by the ettending physician and d be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2: autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place are the time, date are the t 29a. Certifier (Check 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2012 445 Defunse manualy

Registrar DHMH 17 Rev 06-2011

State

641

Annapolis, MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAE

DEC 1

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 42884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month DECEMBER BEATRICE ROBERSON JOHNSON 7:07 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/16/1929 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Country)
LOUISIANA Director 1 □ M 2 🛛 F 436-38-2560 83 Usual Residence of Decedent r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits **Funeral Director** 1 Yes 2 No MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2105 WILLIAMS DRIVE 21078 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ٥ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) INSTRUCTIONAL ASSISTANT PUBLIC SCHOOLS Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MATT ROBERSON ADELLIA PHILLIPS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 2 fitem 27 i Page 1 and 2 BARBARA JOHNSON / DAUGHTER 40 ROYAL TERRACE, ABERDEEN, MARYLAND 21001 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UKN 20c. Location - City or Town, State 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>+</u> 5 Important: I any injury o ARLINGTON NATIONAL ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, cott - Coleman 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final enemic Cardionyo Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law lequires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, age 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by edem 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{\text{Residence}} \) 1 \(\text{6} \) Other (Specify) Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mannet of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number C-Sonow No D0057347 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upper Chesipeate Dr. Del Ar MD 21044 10 C SORIANU MD 31. Date filed (Month, Day, Year) State Registrar

December

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of	f Marylar	nd / Depa				and M	ental Hy	giene	2012	1.0	005
	_	Registrar 1. Decedent's Name (First, Middle	(act)		Cer	tificate	of L	eath		0.0	Reg. No.	2012		885
Physicia		Bertie Frances								2. Date of De	Dav	2012	3. Time o	
Medic Examin		4a. Facility Name (if not institution		ber)		4b. Citv.	Town, or	Location of	of Death	Decemb		County of Death) P
)		Calvert County	Nursing	Center		, ,		Fred				lvert		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under Hours		8. Date of Bir (Month, Da	th	9. Birth	nplace (State	or Foreign
Director		216-12-4185 Usual Residence of Decedent	1 □ M 2 💢 F	92	Yrs.		,			09-08-			and	
and show	ľo	10a. State 10b. County			ity, Town or Loc	cation				07 00_			10d. Inside C	ity Limits
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h the Sa or be no	al D	10e. Street and Number				10f. Zip	Code			-]	10g. Citiz	en of What Cou	intry?	
idiliu ZIZI3-0030 be filed within 72 hours after death with the Maryland ental hygiene. ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Funeral Director		yland Blvd	dent Ever in U	C 110 V	207		an ania Ori	-i=2 (C-+-	if Was as No	USA			
er dea or ite niner	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Mar	Armed Fo	rces? 2 X No	I1	Yes, speci	fy Cubar	n, Mexicar	ı, Puerto F	cify Yes or No- Rican, etc.)	1	 Race - Amer Black, White 		
2-UOSO 2 hours after "natural", o		3 X Widowed 4 □ Divorced	If Man Chi	е	1	☐ Yes 2	No 🛣	Specify:			s	specify: Whi	te	
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Hygir Hygir other ent, t	Be	17. Father's Name (First, Middle, I	.ast)		Clerk	с тур.	ISL	18. Mothe	er's Name	(First, Middle,		<u>ionwide</u> urname)	Insur	ance
d be findental	오	Howard Winfiel	d Trott						gian				reland	
should and N is ma		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailin	g Address	(Street a				er, City or T	own, State, Zip	Code)	
ife, INTALYIGHTU ZIZIS-UUSO 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Franklin Trott	King, Son					y1and	<u>B1v</u>	d., Dui	nkirk	, MD 20	754	
Datuinore Dermit. Page 1 ar Department of He mportant: if iter any injury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		State	Place of Disport cemetery, crem	natory or ot	her place	1		ate		cation - City or 1		
partiti Page 1 a Department of F Important: If its any injury or ot		4 ☐ Donation 5 ☐ Other (\$ 21. Signature of Funeral Service L		Mt	. Harmo					-2012		ngs, MD		
Departing permit popular any irrangement in popular any irrangement irrange		Williams	Cres	MOO		. Name and 325 M			1.040			Home, MD 207		
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eath certificate attending physical for use as the	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								2	3d. Date of deli	/en/	
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ttendi death tor: A	Certificate:	2 Accident Investig	gation	-61-: 0+1-		M		Yes 2 🗆						
after Direc		4 Homicide determ		ng, etc. (Specif	ome, farm, stre	et, ractory,	onice		2	City or Tov		Number or Rura	il Houte Numi	oer,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	29a. Certifier 1 Dertifying	Physician: To the b	est of my know	/ledge, death o	ccurred at	the time	, date and	place, an	d due to the c	ause(s) and	d manner as sta	ted.	anner stated
the H thin 24 the Fi	Me	only one) 3 L Certifying	xaminer: On the bas Nurse Practitioner	: To the best of	my knowledge,	death occu	rred at th	e time, dat	te and plac	e, and due to	the cause(s) and manner as	stated.	anner stated.
6 ½ 6 0		29b. Signature and title of certifier	91.	1		29c.	License	number	CR		29d. Date	signed (Month,	Day, Year)	
		30. Name and address of person	who completed caus	e of death (Iter	m 23a) (Tvpe. P	rint)	\sim	-0-3	J		00	6.110	10 (a	
KWS		JOHN H	- WE	I GEZ	- M) - +	R (1	CE	TR	FRU	CK,	and -	206	78
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Registra	-	HEG & S ZUIZ	Lener.	p. 19	arre									

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State of Maryland / Department of Health and Mental Hydiene

			For State Registrar	State of	iviaryiari		artment of tificate of			ientai Hy	Reg. N	201	2	42886
	Physicia	n/	Decedent's Name (First, Middle,	Last)						2. Date of Do	eath			3. Time of Death
	Medic	al	Betty Louise K 4a. Facility Name (if not institution,				C. 60 T			سعى ق	pos		<u>814</u>	57.15.AM
	Examin	er	10824 Downsvil				4b. City, Town,	rstow			4	c. County of I Washir		,
	Funeral				. Age (In yrs. Ia		If Under 1 Year	r If Und	er 24 Hrs.	8. Date of Bi (Month, D		9		ce (State or Foreign
l.	Director		216-22-2003 Usual Residence of Decedent	1 □ M 2 🗶 F	86	Yrs.	Worth Day	riodis		May 4			,	land
	and show f at	or	10a. State 10b. County		10c. City	y, Town or Loc	ation							d. Inside City Limits
	Maryl 28a-f otified	irec		ngton	E	lagerst	own							1 Yes 2X No
	ith the 3a or t be n	ral D	10e. Street and Number		0.4		10f. Zip Code				10g. C	Citizen of Wha	t Country	y?
	eath wi	Funeral Director	10824 Downsvill 11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13. V	Vas Decedent of	740 Hispanic C	Origin? (Spec	cify Yes or No	-	USA 14. Race - A	Americar	Indian,
030	should be filed within 72 hours after death with the Maryland and Mental Hygiene. ' is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Marri 3 🛣 Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	2 💢 No	If	Yes, specify Cu	ban, Mexic	an, Puerto F	Rićan, etc.)			White, etc Whi	
Maryland 21215-0036	72 hour an "natur Medical I	Completed	(Specify only highes	t's Education st grade completed)		(Give k	ent's Usual Occi ind of work done O NOT use retire	during mo	ost of workir	ng	16b.	Kind of Busin	ess/Indu	stry
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and	e filed ntal H) ed oth eveni	To Be	17. Father's Name (First, Middle, La	,						(First, Middle		,		
ž	ould b nd Mer mark imatic		John Paul Smith 19a. Informant's Name/Relationsh			I 19h Mailin	g Address (Stree			ne Eli				de) 21740
		7	Kathleen Kountz		er	T	Downsv							21740
Baltimore,	ge 1 and 2 should be it of Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 X Cremation		20b. P	lace of Dispos	sition (Name of natory or other pi			ate		Location - Cit		
Ē	t. Pag rtment rtant:		4 Donation 5 Other (S	pecify)	На									Maryland
D D	permit. Page 1 and 2 Department of Health Important: If item 2' any injury or other t		21. Simure of Funeral Service	Dun	miel	4	Name and Add							and 21740
	Physician Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each	used the death h line. r as a consequ	epo		ring, such a	as cardiac o	r respiratory a	rrest,		- 11	opproximate nterval Between onset and Death
	executed an and rial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last	с.	r as a consequ									
O. BOX 68/60	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		irth 2 🗔 Feta ant at time of d	ıl death 3 🗌	Ectopic pregna	ncy				23d. Date o Month	-	ay Year
J.	uires that n signed I uld be def	by	Part II. Other significant conditio	ns contributing to dea	ath but not res	ulting in the u	nderlying cause	given in Pa	rt I.		,			cause of death?
or vital Records,	he law req ite has bee bage 2 sho	Completed								24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?	- vio	r to comp	y findings available oletion of cause of
<u></u>	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	The state of					eath (Check		2 1	10	100 2	
<u> </u>	Physik this c	은	1 Yes 2 No	Hospital: 1 In 28a. Date of	patient 2 -	ER/Outpatien	t 3 DOA O			me 5 Res			Specify)	
<u> </u>	nding ith. : After e fune	cate	Natural 5 Pending	g (Month,	, Day, Year)	injury	wc	ork? ☐Yes 2	[ad. Describe	now inju	iry occurred		
DIVISION	l or Atter after des Director d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	not be 28e. Place of	f Injury - At ho g, etc. (Specify		eet, factory, office	9	2	28f. Location City or To			r Rural R	oute Number,
_	e Hospita 124 hours Euneral letely filler	Medical	(Check 2 ☐ Medical E :	Physician: To the bes xaminer: On the basis Nurse Practitioner: 1	of examination	n and/or invest	igation, in my opi	nion, death	occurred at	the time, date	and plac	e, and due to	the cause	e(s) and manner stated.
	To th withir To th comp	2	29b. Signature and title of certifer	\$1	2001 0111	,oo.go,	29c. Licer	se number			29d. D	ate signed (M		
	. A						Dec	ادر	Q X	40	1/2	can	TRE	-14,201
	2		30. Name and address of person v	no completed cause	WAF,	ans	9 saint	Panl	59:	25	Dest	وورو	10	MD 2(7)
	Stat Registra		31. Date filed (Month, Day, Year)	2012	gistrar's Signat	A.								

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Ma	ii yiaiiu 7		tificate of D		_	Reg. No	2011	2 42887		
	Physicia	n/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day,							av Year	3. Time of Death			
,	Medic	al	Mary Bozarth Ke 4a. Facility Name (if not institution, or				4h Cihi Taum an	Location of Dooth	~	1				
	Examin	er	8114 Laurel Ridg		4b. City, Town, or Location of Death Frederick					4c. County of Death Frederick				
	Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last b	irthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		9. Bir	thplace (State or Foreign untry)		
	Director		464-44-0486 Usual Residence of Decedent	1 □ M 2 🔀 F 8	6	Yrs.			Dec. 2			lahoma		
	show dat	tor	10a. State 10b. County		10c. City, To	wn or Loc	eation	<u>'</u>	•			10d. Inside City Limits		
	hiled within /2 hours after death with the Maryland the Hygiene. Hygiene at Other than "natural", or items 23a or 28a-f show to other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	Director	Maryland Fred	erick	Frede	erick						1 ☐ Yes 2 🖾 No		
036		Funeral D	10e. Street and Number 8114 Laurel Rid		10f. Zip Code 21702					10g. Citizen of What Country? United States				
		þ	Marital Status Never Married 2 ☑ Married Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates.		- 1	vas Decedent of His Yes, specify Cubar ☐ Yes 2 🏻 No		ecify Yes or No- Rican, etc.)		14. Race - Ame Black, White Specify: W			
9500-612	hour 'natur' dical	olete	15. Decedent's Education (Specify only highest grade completed)		16	16a. Decedent's Usual Occupation (Give kind of work done during most of working					16b. Kind of Business/Industry			
2	thin 72 ane. than '	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+	+)	life. DO	nd of work done d. NOT use retired) Homemaket		ung	Ι,	Own Home			
	filed wi al Hygie d other vent, tl	Be	17. Father's Name (First, Middle, Las	t)			nomemaker	18. Mother's Nan	ne (First, Middle,					
Jan	d be fi Menta arked atic ev	ဍ	Hugh W. Bozarth			Belle Thompson					•			
Man.	1 and 2 should be if Health and Men item 27 Is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)			19b. Mailing Address (Street and Number or Rural Route Number					ber, City or Town, State, Zip Code) erick, Maryland 21702			
e) D	and 2 : Health tem 27		Jim Keirsey / Hu 20a. Method of Disposition	sband			Laurel Ki	ldge Road	, Frede		ocation - City or			
Baltimore, Maryland	permit. Page 1 a Department of I Important: If its any injury or ot		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecify)	ceme	tery, crem fer	Crematory or other place	y Inc.12	12/12	Fr	ederick,	Maryland.		
g	permi Depar Impor any ir		21. Signature 15 of ral Service 1	MAN	1						rick, Ma	ryland 21702		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
, P	nysician/ ,Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death											
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	y the attendiched for us	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ੴNo 9 ☐ Unknown	1 Live Birth 2 Fetal death 3 Ectopic pregnancy							23d. Date of de Month	livery Day Year		
٠ ن	s that t gned b se deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?											
S D	equire een si	eted	ANEMIA, PRURITIS, CHF, THYROTOXICOSIS 1 Yes 2 No 3							!□No 3□P	robably 4 Unknown			
Hecords,	Attending Priysical: The law requires that the deam schort After this certificate has been signed by the atte by the funeral director, page 2 should be detached for	Completed by	autopsy prin performed? 1 □ Yes 2 □ No							prior to death?	topsy findings available completion of cause of			
VITAI		Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Otho	ace of Death (Chec						
> 0	g Physer this neral d	e: To	27. Manner of Death	1 ∐ Inpatier 28a. Date of injury (Month, Day,		. Time of	t 3 ∐ DOA [28c. Injury	4 ∐ Nursing H	ome 5 Resi 28d. Describe l	•	6 ☐ Other (Spec ry occurred	ify)		
5	to the propriet of Attentioning Propertient. The taw requires that the death certil within Exh burst after death. To the Funeral Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use.	ficat	1 Natural 5 Pending 2 Accident Investigat	rear)	injury work? M 1 ☐ Yes 2 ☐ No									
UNISION		Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify)				eet, factory, office		(Street and Number or Rural Route Number, wn, State)					
_ [Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	Mit Vitt		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 · 11 · 2012											
	4	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4. WHELSON ND 65C Thomas Johnson DR. FREDERICK, MD 21702									21702			
	Sta Registra		31. Date filed (Month, Day, Year) DEC 13	2012 32. Fi-gistrar	r's Signature	1. 4	arkel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alexander M. Kombe 2012 December 7:20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8918 2nd St. Prince George's Lanham 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Hours 320-54-1894 66 **Director** 1 XM 2 D F Sept. 17, 1946 Tanzania Usual Residence of Dece ms 23a or 28a-f show must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo MD Prince George's Lanham 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8918 2nd St. 20706 Tanzania or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural", Specify. 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Broker Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ပ Lazaro Kombe Helen Mtengie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 8918 2nd St., Mary A. Kombe / Wife Lanham, MD 20706 20c. Location - City or Town, State Africa 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I Important: If its any injury or of once. 1 X Burial 2 Cremation 3 X Removal from State 12/24/2012 4 ☐ Donation 5 ☐ Other (Specify) Kombe Cemeterv Kilema, Tanzania 21. Signature of Frine at Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., M01442 Bowie, 23a. Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner One Year Metastatic Lung Cancer Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury One Year Pleural Effusion To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ! use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has npletely filled in by the funeral director, page 2 · autopsy performed? Yes 2**X** No 1 🗌 Yes 2 🗶 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 X No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5XXResidence C 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd. Suite 101 Lanham MP20106 801-Green Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Carol H. Allan, MD

31. Date filed (Month Da Year)

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

December 12, 2012

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Kellner Kenneth 12 20,1 Vecamber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2 □ F 73 213-34-4312 Jan. 17, 1939 Maryland **Director** Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County Injury or other traumatic event, the Medical Examiner must be notified at Baltimore Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21224 "natural", or items 23a 7308 Stratton Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1961
1 🖾 Yes 2 🗆 No 1967
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify Completed by 3 XWidowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) Warehouse Paper 12 and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event Be May Kellner Edward Kellner ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Blue Spire Circle Baltimore, MD 21220 Donna Peters / Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) December 15 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD Metro Crematory, INC. 2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DIRECT 21. Signature of Funeral Service Licensee 495 Ritchie Hwy Severna Park, MD 21146 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart fature. List only one cause on each line. Stroke immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Preumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician Box 68760 Physician/Medical 23b. Was decedent pregnant Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Records, 1 Yes Completed 24a. Was an autopsy has performe of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 🗆 DOA ရ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manufer of Death 28c. Injury at Work? Certification: 5 Pending investigation Division 1 Tes 2 No 2 Accident 3 Suicide Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Medical (check only 29c. License number

23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, I 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) December 12, 2012 RES-000 30. Name apaddress of person who completed cause of death (Item 23a) (Type, Print) 411 Schreele 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Mont) State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

10d. Inside City Limits

1 ☐ Yes 2X No

13:17

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Catherine L. Kent December P^{M} Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3803 Corbett Place Bowie Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Days Hours 214-40-1703 Director 70 1 M 2 X F Yrs July 28, 1942 Washington, D.C Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a or Funeral 3803 Corbett Place 20715 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, med Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed er than "natur , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Own Home alth and Mental Hygien 27 is marked other the traumatic event, the Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unknown Catherine Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Kent, Sr./Spouse 3803 Corbett Place, Bowie, MD 20715 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Metro Crematory Dec.15,2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Inter the disease, or co his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line. shock, or heart failure. List only of Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition resulting in death) cancer Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) physician the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Division of Vital Records, P.O. Box 68760 as 1 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? signed by the atter Month Day Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributin*g* to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated and a should? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number D35820 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peter ECKBERG M.D. Gallant For Lane #110 14(300 30WE 31. Date filed (M State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42892 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 5 2012 Physician/ Elmer Paul Krause 9:34 P^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) 89 Director 579-22-5747 1 ⊠ M 2 □ F 26, 1923 Illinois 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23e or 28a-f s Examinar must be notified 1 X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? Funeral 2171 Ambleside Court 21702 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Quality Control Foreman Film Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mentel h t. Pege 1 end 2 should be fill tment of Health and Mentel rtent: If Item 27 is marked ၉ Otto M. Krause Martha Hof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2171 Ambleside Court Frederick, Maryland 21702 <u>Carol Kaas / Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I-Importent: If ite any injury or ot December 1 Burial 2 Cremation 3 Removal from State 10, 2012 4 Donation 5 Other (Specify) Stauffer Crematory Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 10 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ardingenis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pulmonary Sequentially list conditions, Examine sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ettending physician end I for use es the burief-trensit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) al or Attending Physicien: The law requires that the deas safter death.
I Director: After this certificete hes been signed by the etd in by the funeral director, page 2 should be detached for in by the funeral director, page 2 should be detached for the funeral director. P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 1 🕅 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funerel Director: Aft completely filled in by the fu 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier Nam 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

MY UNG HEE NAM
31. Date filed (Month, Day, Year)

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FREDERICK, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g935 1-25-13 vt. State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 18 2012 Harry Franklin Kendle 9:28 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Broadmore Senior Living Hagerstown Washington . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 220-26-5063 Director 1 X M 2 □ F 95 March 23, 1917 Maryland Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic approach. 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 ☐ Yes 2 🂢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20112 Beaver Creek Rd. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Farmer Be 17. Father's Name (First Middle, Last)
Preston Milford Kendle 18. Mother's Name (First, Middle, Maiden Surname) ည Martha Isabelle Stine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imogene A. Kendle-wife 20112 Beaver Creek Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 12-22-2012 Boonsboro, MD Boonsboro Cemetery 22. Name and Address of Facility Douglas A. Fiery Funeral Home Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ementia disease or condition years Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Ninknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie P128088 02 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

12-09683 Deborah Ann La	ıgan	Please Type State	or Print in E							gible.	012	42891
		1- For State Registrar			rtificate of			-		Reg. No.	UIL	4200
Physici Medical Exami	_	Decedent's Name (First, Middle, Lager Deborah Ann Lager)							2. Date of De Month		/ear	3. Time of Death 1900 hrs
medical Exam.		4a. Facility Name (if not institution, g		er)		4b. City, T	Town, or Lo	cation of Death			ty of Death	
		4301 23rd Parkway #605				Temple Hills Prince George's						
Funeral Director			6. Sex 7. Age (In yrs. last birthd			If Under 1 Year If Under 24Hrs. Months Days Hours Min.			For			n
Bircotor		579–86–4204 1	M 2 <u>X</u> F .	53	Yrs				July	30, 195	9 Wa	shington D.
/ any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
land f shov	ē	Maryland Prince George Temple Hills									1 Yes 2 No	
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 10f. Zip Code 4301 23rd Parkway #605 20748								10g. Citizen of U.S.A		itry?
5-0036 led within 72 hours after death with the Maryland stygene. Worter than "matural", or trems 23a or 28a-f she the Medical Examiner must he motified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 1 Never Married 2 Married Armed Forces?										
after de	by Fu	21	ed If Yes, Give Year or Dates:	2X No	1		71			Specif		
hours natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade of College (1-4 of					(Give kind of w O NOT use retir		16b. Kind of	Business/I	ndustry
036 thin 72 ne.	Completed	11	Jonego (1 7 c	0.,	Inst	all	Sales	Clerk		Home	Impro	vement Stor
21215-0036 uld be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle, Las			•			Mother's Name	,,,	Maiden Surnar	ne)	
2121 ald be f Mental marke event	To Be	Francis Leroy O 19a. Informant's Name/Relationship			19b. Mailing	Address		Ruth An		mber. City or T	own. State.	Zip Code)
MD 3 d 2 shot lth and lth and lth um 27 is		Sandra Lagana	Mother-I	n-Law				t., Tem				
	ĺ	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from	20b.	Place of Dispos crematory or oth	ition (Nan her place)	ne of cernet	ery, ember 28	Date 2012	20c. Locatio	n - City or	Town, State
Baltimore, permit. Pages I an Department of Hec Important: If ite		4 Donation 5 Other Specia			cinity M	<i>lemor</i>	ial G	ardens			rf, M	aryland
Ball permit Depart Impor injury		21. Signature of Funeral Service tion	ensee	M006	568 ^{22.} V	lame and Villi 1270	Address of ams F	uneral	Home,	P.A.	a Ma	l. 20640
Physician Medical Examiner		23a. Part I. En er the disease, or confailure. List only one cause on Immediate Cause (Final disease		ed the death	. Do not enter ti	he mode o	of dying, su	ch as cardiac o	respiratory ar	rest, shock, or	heart	Approximate Interval Between Onset and Death
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	xaminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cor									
executed an and al - transit	ш	d										
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death "a Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	Completed								24a. Was auto perfo	psy orm <u>ed</u> ?	prior to or death?	opsy findings available ompletion of cause of
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Vita hysicia this ce	To B	examiner? 1 ✓ Yes 2 No		tient 2	ER/Outpatient				g Home 5	Residence 6		Scene
on of Viranding Physicath	Eigi	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 28d. Describe how injury occurred										
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death After this certificate I To the Funeral Director: After this certificate I completely filled in by the funeral director, page	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)									ral Route Number, City	
To the Hos within 24 hc To the Fun completely i	Medical ((Check only	cian: To the best of er:On the basis of ex and manner state	kamination a	-							
F 3 F 8	Me	29b Signature and title of certifier	and manner state		<u> </u>	290	License n					th, Day, Year)
		MI		1	1/		O.C.M.I	E.		Decembe	er 20, 20	12
^/\	1	30. Name and address of person who	completed cause of	f death (Item	1 23a)							

Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State 31. Date filed (Month Park Y27) 7 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 8:55 PM Anne J. Lynch December 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 15 Old York Court North East Cecil If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 - M 2 X F **Director** 211-20-5192 95 May 20. 1917 |Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 🗌 Yes 2 💹 No Maryland | Ceci1 North East ō 10e. Street and Number 10g. Citizen of What Country? **23**a Funeral 15 Old York Court 21901 United States items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. than "natural", or 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha <u>Nurse/Anesthetist</u> **Healthcare** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 sh tment of Health a tant: If item 27 is Christine Bolcer / Daughter 15 Old York Court, North East, Maryland 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot December 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mayerdale Crematory 15, 2012 Newark, Delaware 21. Sign fur of up al Se of Leense 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, List only one cause on each line. Immediate Cause (Final Onset and Death DNG (ARLINON A Physiciani Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Due to (or as a consequence of): Exami that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Live Birth 2 L retail uses.
Pregnant at time of death ō Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed A. Filmledion 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 \square No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

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State

P. V. Namse

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Register's Signature

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STAUL , ELKION HD 21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17 Day 2012 Year Physician/ Dec. 8:05 Elizabeth Lottie Linton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington 236 Taylor Avenue Hagerstown 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Hours Min. Director 200-22-5642 90 1 □ M 2 🛛 F Yrs Feb. 27 1922 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1**X** Yes 2 □ No Maryland Washington <u>Hagerstown</u> 10f. Zip Code ms 23a or must be n 10e Street and Number 10g. Citizen of What Country? Funeral 236 Taylor Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: "natural" Completed 3 X Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Roy O. Smith Nellie M. Williard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Webster - Daughter 830 Georgia Avenue, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Lawn Mem. Park 12/20/2012 Hagerstown, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ? shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month ate has been signed by the a page 2 should be detached in 1 ☐ Yes 2 ← 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 2 🗆 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 I ER/Outpatient 3 DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural Pending 1 Yes 2 No To the Hospital or Attendi within 24 hours after death, To the Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0,2:52AM ockle 201. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mary land Medical Center of University timore 5. Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Hours 219-44-4098 Director 1 X M 2 □ F 67 July 21,1945 Maryland ed other than "naturel", or items 23a or 28a-f show event, the Medical Examinar must be notified at 10a. State 10h County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Washington Maryland Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 11 West Baltimore St. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Cook Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental F permit. Page 1 and 2 should be file Department of Health end Mental I Important: If item 27 is marked of any injury or other traumatic eve ance. ည James Combs Mary K. Lockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances M. Lockley-sister 318 North Prospect St. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 12-18-2012 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Pouglas A. Fiery Funeral Tiome 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hemorrhage disease or condition Medica resulting in death) Due to (or as a consequence of) Examiner bdominal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi Cause (Disease or injury that initiated events Necohzing Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No detached the 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 \(\sum \) Yes 2 \(\sum \) No this certificate funeral director, æ 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of After t 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending I Director: A Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after
To the Funeral Directory Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Baltimore, Maylon State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State
 Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:18 A Rosina Miles December 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 Months Hours May 20 Day, Director 88 Virginia 219-16-1708 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No Maryland Charles Waldorf 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 2006 Wedgewood Place Apt. 20602 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify White 3 Midowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant; If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th. <u>Check Checker</u> Citi Bank or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Boley Pauline Moravitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13368 Colchester Ferry Place, Paula Martin/ Daughter Woodbridge, VA. 22191 20a. Method of Disposition
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant; If ite cemetery, crematory or other place injury (4 ☐ Donation 5 ☐ Other (Specify) Hill Cemetery Dec. 14, 2012 Suitland, Maryland 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service lio nsee <u>Old Washington Rd. Waldorf, MD.</u> omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Enter the diseas Part 1 Approximate or heart failure. List o Interval Between Immediate Cause (Final Onset and Death Ph_ician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any leading to immediate Physician/Medical Examiner if any leading to immediat cause. Enter Underlying Due to for as a nonsequence of the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Dav g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? ☐ Yes 2 🗘 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 🕅 No 1 🗌 Yes Other: မ 1 Nipatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending work? s after death. Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or

To the Funeral Direct
completed filled in by filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 243371 30. Name and address of person who completed cause of deats (Item-23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

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Physicia al Examir	in/ ner	Decedent's Name (First, Middle Harry	Phillip		1	Maus,	Jr.			. Date of De Month December	Day er 14,		r	3. Time of 0118	
		4a. Facility Name (if not institution Meritus Medical Center			41	c. City, Tow Hagerst		cation of	Death			c. County o			
Funeral	- 1	5. Social Security Number		(In yrs. last birthd		If Under 1 Months	Year Days	If Under Hours	24Hrs. Min.	8. Date of E			Foreign	1	ate or yland
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ow any		10a. State 10b. County MD Washi	ington	10c. City, Town or Hagerst		on									le City Limits
faryland	Director	10e. Street and Number		21480111		10f. Zip Co	de				10g. C	tizen of Wh	nat Coun	try?	
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		9212 Cool Holl	12. Was Decedent I	Ever in U.S.	13. Was	2174 Decedent	of Hispa	anic Origi Mexican,	in? (Spe Puerto F	cify Yes or Nican, etc.)	10-	U.S. I 14. Race White	- Americ	can Indian	, Black,
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6 172 hours an "naturical Exami	Completed t	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (1-4 or 5	du (+)	iring mo	's Usual Oc st of workin Techn	g life. [OO NOT	use retire	ed)		utomo			
21215-0036 wild be filed within 7 Mental Hygiene. marked other than		17. Father's Name (First, Middle		III	ick_	recin		3.Mother		First, Middle	, Maide	n Surname)	· · · · · · · · · · · · · · · · · · ·	
2121 ould be fi Mental I marked ic event,	To Be	Harry Phillip 19a. Informant's Name/Relations	ship (Type, Print)					and Num	ber or R	ural Route N	umber,	City or Tow	n, State		1740
and 2 sho ealth and tem 27 is traumati		Lauren R. Maus 20a. Method of Disposition		20b. Place of	Disposi	tion (Name			Terr	ace, E		C. Location			
Baltimore, permit. Pages I an Department of Hea Important: If itelinjury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other S	pecify:	Rest H	aver					9/201					
Balti permit. Departn Importi injury		21. Signature of Funeral Service 5. Mark 5 23a. Part I. Enter the disease, o	Licensee		160	01 Per	nsy	lvan	ia A	t Hav	Hage	erstov	vn, I	MD 2	21742 imate Interval
Physician kaminer	Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	e Intoxi equence of):			7asc		T DIS	sease	com;	plica	ted		en Onset and Death
executed an and al - transit		X UNPENDED	d AMENDED23a	,27,28a-i	f,pe	r me,	g93	5 1-	7-13	sm					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 Ur	23c. If yes, outcor 1 Live birth 4 Pregnant at	me of pregnancy	Fe	tal death her (Specif	3 [Ectopie				23d. Date o Month		y Day	Year
b.O. Bothat the deded by the	by Phy	Part II. Other significant cond		h but not resulting	in the u	ınderlying c	ause gi	iven in Pa	art I.			co use cont			of death? Unknown
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Completed									pe	as an atopsy erformed	<u>4</u> ?	Were at prior to death?	completion	lings available of cause of
zal Re ian: Th certificat	Be Co	25. Was case referred to medic examiner?		- [7]			_			only one) g Home 5	7 800	eidopse 6	Othe	ır.	
of Vil g Physic fter this	은	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,)		ime of I		c. Injur	y at Worl	k?	28d. Descri	be how	injury occur	rred	<u> </u>	
r Attendin r Attendin ler death. irector: A	Certification:	1 Natural 5 Per 2 X Accident Inv 3 Suicide 6 Co	estigation unk 28e. Place of Ir	un] njury - At home, fa		et, factory,		es 2 X uilding, e		subject 28f. Location or Tow	n (Stre	et and Num	ber or R		Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i	I Certi		ermined (Specify)	unknown ny knowledge, dea	th occu	rred at the t	ime, da	ate and pl	lace, and	due to the	ause(s	unkno	er as sta	ted.	
Fo the F within 2- or the F	Medical	one) 2 Medical Ex	taminer: On the basis of exa and manner stated	amination and/or ir	rvestiga	tion, in my	pinion	, death o	ccurred a	at the time, d	ate and	place, and od. Date sig	due to t	he cause(
	Ž	0-04.				290.	O.C.I					ecembe			
It		30. Name and address of personal M. Vincenti,		death (Item 23a) cal Examiner	900	W. Balt	more	Street	, Baltir	nore, MD	2122	3			

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

31. Date filed (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Mame (First, Middle, Las 2. Date of Death 3. Time of Death Physician/ IPYS 6:11A DPC COMPE V Medical acility ot institution, give streef and number) n, or Location of Death 4c. County of Death Examiner Name (f 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** (Month, Day, Year) 215-90-4359 1 🗆 M 2XX Director April 7,1962 Maryland 50 should be filed within 72 nouse and Mental Hygiene.
and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show
marke event, the Medical Examiner must be notified at 10b Count 10c. City, Town or Location 10d. Inside City Limits Director ¹XXX Yes 2 ☐ No Washington Williamsport Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21795 USA 32 N. Vermont Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Catering Server other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Geraldine May Derr Augustus Starliper 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 N. Vermont St. Williamsport, Maryland 21795 Roy M. Myers, Sr. - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Greenlawn Mem. Park Dec.19,2012|Williamsport,Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Osborne Funeral Home, P.A. Signature of Funeral Service Life 425 S. Conococheague St.Williamsport, MD 21795 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 10 cardia Infarction disease or condition Medical resulting in death) Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Fried II delying Cause (Disease or injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 No Month Day Year 9 Unknown P.O. signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🔲 Yes 2 No Other: ဍ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending illed in by the fu 1 ☐ Yes 2 ☐ No after death. Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) RES-000 December 16, 2012 30. Name and address of person who completed Saho State DEC Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12,2012 Roger Walter Miller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) April 12,1928 Davs Country Director 212-24-7240 1 ¥ M 2 □ F 84 Yrs. Maryland 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Clear Spring Maryland Washington 10e. Street and Number 10g. Citizen of What Country? Funeral 14340 Rockdale Road 21722 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 ☐ No If Yes, Give Year or Dates. 1949-1953 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Authority 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hagerstown Housing Executive Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Summers Walter Edgar Miller Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14340 Rockdale Road, Clear Spring, Maryland 21722 Olivia V. Shank-Miller Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 12-13-12 Hagerstown, Maryland 21. Signature of Funeral Service License Andrew K. Coffman Funeral Home, Inc. -K. hoel 40 East Antietam Street, Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ newwow. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner c105tn; d:Um Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit Renal A cent c Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performe or Attending Physician: The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** B 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 1 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mariner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of I Director: After t ed in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours of To the Funeral Completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier D060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IW 5+1 MUNSHED ARIO

State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registra MEND#26+29 doe: MD, 12/17/12; BW, MCC Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mendoza Physician/ Month Sabel 605 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) Country 220-33-6353 Director 1 🗆 M 2 💢 F 93 Yrs 19, 1919 Honduras Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any Injury or other traumatic event, the Medical Event is a must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8109 Tahona Drive, Apt. 202 20903 Honduras 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1XI Yes 2□No Specify: Honduran White Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) စ Antonio Mendoza Margarita Escobar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosaly J. Vandervelden/Granddaughter 6202 Straughn Court, Laurel, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 1 2012 18 Jardines del Recuerdo San Pedro Sula, Honduras 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Disease Onset and Death Physician/ 0 RONAR Medical resulting in death) Due to (or as a consequence of): Examiner HYPOTHYROID ISN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the buriabteas! Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Pregnant at time of death Day 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 1 ☐ Yes 2 ☐ No 24 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 🗌 Yes 2 X No Other: ၉ 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 4 Nursing Home Stat Resid after death. 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours at To the Funeral D completely filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IL VETTILE MIL 7700 Carroll Avenue, Takoma Park, MD 20912

State

Registrar

31. Date filed (Month, Day, Year)

4

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 0 | 2 42903 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 12, 2012 Concetta De Maria 1:17PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 143-12-1543 96 **Director** 1 □ M 2 🖾 F Nov. 1, 1916 NJ or 28a-f show a notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No P.G. Hyattsville 10e. Street and Number | Hygiene. | other than "natural", or items 23a or vent, the Medical Examiner must be r 10g. Citizen of What Country? Funeral 4916 La Salle Road, Apt. 23 20782 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 12 Never Married 2 Married þ Specify.White Maryland 21215-0036 1 ☐ Yes 2 A No Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file 1 and Mental I 1 is marked o Anthony De Maria Giovanna Cavaliere 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Maria Stephens/Niece 25608 Jarl Drive, Gaithersburg, MD 20882 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or or Dec. 13, 2012 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria,VA 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. voish MO 1503 500 University Blvd. W. Silver Spring. MD 20901 Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Sepsis Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the buriat-transit Cause (Disease or injury that initiated events resulting in death) Last c. Urinary Tract Infection Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dehydration, Hyperkalemia, Coronary Artery Disease, Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Congestive Heart Failure performed? 1 ☐ Yes 2 🖾 No filled in by the funeral director, Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 1 XInpatient 2 ER/Outpatient 3 DOA of To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 1 X Natural injury 5 Pending Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioners to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D72726 December 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, MD 20814 Lori Pihl, MD 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State DEC 1 4 2012 Registrar

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Md Lislo

2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and I		ene 1.No.2012 42904
	Physicia	m/	Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
~~~	Medic	cal	Louis Alfred Masciocchi			11, 2012 1:10 am
	Examir	ier	4a. Facility Name (if not institution, give street and number)  Holy Cross Hospital	4b. City, Town, or Location of Death Silver Spring		4c. County of Death  Montgomery
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	<del></del>	8. Date of Birth (Month, Day, Yo	9. Birthplace (State or Foreign
	Director		171-24-4716  Usual Residence of Decedent  1 ^X M 2 □ F  89  Yrs.	World Days Hours Will.	Feb. 2,	
	land show d at	후	10a. State 10b. County 10c. City, Town or L	ocation	_	10d. Inside City Limits
	Mary 28a-f notifie	Director		ver Spring		1 ☐ Yes 2X No
	s 23a or	Funeral D	10e. Street and Number 10208 Edgewood Avenue	10f. Zip Code 20901	10	g. Citizen of What Country? <b>USA</b>
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No If Yes, Give 1944–46  Year or Dates.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
15-0	72 hour	Completed	15. Decedent's Education (Specify only highest grade completed) (Give	edent's Usual Occupation b kind of work done during most of work DO NOT use retired)	ing 16	Sb. Kind of Business/Industry
212	within giene. ler tha t, the I		College (1-4 or 5+)	orney		Law
Baltimore, Maryland 21215-0036	l be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) Angelo Masciocchi		ne (First, Middle, Mai Del Sole	,
Mary	2 should th and N 27 is ma trauma			ing Address (Street and Number or Rur		
Ē,	f Heal item 2		20a. Method of Disposition 20b. Place of Disp	08 Edgewood Avenue osition (Name of		Spring, MD 20901  Oc. Location - City or Town, State
<u>im</u>	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) entombment Gate ρ		17, St	llver Spring, MD
Balt	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee	2 Name and Address of Facility Trancis J. Collins 00 University Blv	Funeral d. W,. Si	Home Inc. Iver Spring, MD 20901
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)  Acute Cerebrovasc  Due to (or as a consequence of):	ular Accident		Onset and Boarn
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	icate be executed globysician and as the burial-transit	Examine	Cause (Disease or injury that initiated events c.			- 2
0	be exersician se burial	ical	resulting in death) Last  Due to (or as a consequence of):			
876	tificate ng phy e as th	Med	IF FEMALE:			
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live Birth 2 Fetal death 3	Ectopic pregnancy     Other (specify)		23d. Date of delivery Month Day Year
P.0	that the	by Pł	Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobac	cco use contribute to the cause of death?
rds,	equires een sig nould b	ted	Coronary Artery Disease, Hypertensio	n	1 🗆 Yes	2 No 3 Probably 4 Kunknown
Reco	The law re ate has b page 2 sh	Completed			24a. Was an autopsy performe	
ta	ician: Sertific ector,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (Chec	_	
∑ Z	r this eral dii	e: To	1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of		ome 5 Residence 28d. Describe how	ee 6 Other (Specify)
ono	ending sath. rr: Afte he fun	ficat	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	work? M 1 ☐ Yes 2 ☐ No	200. 00001100 11077	injury occurred
Jivisi	al or Atters al all all all all all all all all all	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
_	ne Hospit n 24 hour ne Funera pletely fille	Medical	29a. Certifier  1	stigation, in my opinion, death occurred a	t the time, date and p	place, and due to the cause(s) and manner stated.
_	Veithing To the Comp.		29b. Signature and title of certifier	29c. License number	1	. Date signed (Month, Day, Year)
	י דען '		grand.	D66249		December 11, 2012
				len Road, Silver S	pring,MD	20910
H	Stat Registra	.е	31. Date filed (Month, Day, Year)  DEC 13 2012  32 Registrar's Signature	Ald.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\overset{\text{Day}}{6}$ , Doris Allen McFadden 2012 December 9:37 p. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F 1271871920 **Director** 225-10-5450 Virginia Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick 1 ☐ Yes 2 🛣 No Frederick 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 7407 Willow Road 21702 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant City Government is marked other aumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin P. Allen Dolly Mae Woolfrey Department of Health and Important: If item 27 is n any injury or other traum. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith McFadden / daughter 6250 Glen Valley Terrace, Unit J, Frederick, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 12-12-2012 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Adver nmiz disease or condition Medical resulting in death) Due to (or as a consequence of): >20 yrg. Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine 2 days. Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis. yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 \( \sum \) Yes 2 \( \sum \) No Month Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes Other: Certificate: To 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, document and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 20c License number CRAST

Registrar DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

31. Date filed (Month, Day, Year)

Wolfe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month December William Lee Massey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KEGIOHAL MEDICAL NICOMICO TENIN346A SALISBURG Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Min (Month, Day, Year) Director 217-42-5082 1 XM 2 F 11-6-1943 69 Usual Residence of Decedent or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits permit. Page 1 end 2 should be filed within 72 hours after death with the Man Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-1 any injury or other traumatic event, the Medical Examiner must be anxietted once. 1 X Yes 2 No Dorchester Hurlock MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Wrights Avenue 21643 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. É 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 ☐ Widowed 4 🔀 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Retail Food Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edmond Massey Maude Jaynes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Deborah Harding/daughter</u> 304 Wrights Ave. Hurlock, MD 21643 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Midshore Cambridge, Center 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 308 High S Cambridge St. Newcomb&Collins FHMD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consultence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires thet the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month signed by the at Id be detached for 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 LUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed? Yes 2 No 2 🔲 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 K No Hospital Other: ၉ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending work? ☐ Accident 2 🗌 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carrol15t. SAlisbury ildman Md 21801 31. Date filed (Month, Day, Year) . Registrar's Signature State 13 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Derek H. Munro		1- For State Registrar	ate of Marylar	-	artment of rtificate of		Mental F		Reg. No. 2 (	)   2 4290
Physici Medical Exami		1. Decedent's Name (First, Midd						2. Date of Dea		3. Time of Death 0226 hrs
		4a. Facility Name (if not institution W/B Speilman Road	on, give street and num	ber)	4	b. City, Town, or L Fairplay	ocation of Deat		4c. County o Washing	
Funeral Director		5. Social Security Number 214-33-9807	6. Sex 7	. Age (In yrs. I		If Under 1 Year Months Days	If Under 24Hr Hours Min	n.	irth(MM/DD/YYYY) 2,1991	9. Birthplace (State or Foreign Country) Maryland
Maryland 28a-f show any d at once.	ctor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Wasł  10e. Street and Number	nington	10c. City	, Town or Locatio	williams	sport		40	10d. Inside City Limits 1 Yes 2 XXNo
or items 23a or	ed by Funeral Director	10905 Kemper I  11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div	arried 12. Was Deced Armed Ford 1 Yes orced If Yes, Give Year or Dates: cify only highest grade	ces? 2 No completed)	If Ye	·	Mexican, Puerto specify: n (Give kind of	pecify Yes or No o Rican, etc.)	o- 14. Race - White, Specify: 16b. Kind of Bus	USA -American Indian, Black, etc. White
5-003( ed within tygiene. other tha	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Edward Henry	Last)			Student	3. Mother's Name	,	Maiden Surname)	ation
MD and 2 sho	ם	19a. Informant's Name/Relations Edward H. Munro 20a. Method of Disposition 1 Burial 2 X Cremation	),III - Fat	20b. F	10905 Place of Disposit	Kemper I ion (Name of ceme er place)	and Number or Orive Wil	Rural Route Nur	mber, City or Town Oort, Mary 20c. Location - C	
Baltimore, permit. Pages I ar Department of Hee Important: If ite	(4	4 Donation 5 Other Scriptore Supplied of Juneau Strvice 23a. Part I. Enter the disease, or	Licensee		22. Na 425	s. Conoc	Facility Osl Cocheagu	orne Fu ue St.Wi	neral Ho lliamspo	me, P.A. rt, MD 21795
/Medical examiner	l Examiner	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usass of it in the last events resulting in death) Last		onsequence of	r):			_		Between Onset and Death
	Physician/Medical	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in th past 12 months?  1 Yes 2 No 9 Unk	e 23c. If yes, out	come of pregr t at time of dea	2 Feta	r 13e sm 936  I death 3 or (Specify)	5 2-13-		23d. Date of d	elivery Day Year
cords, P.O. law requires that the has been signed by	Completed by P	Part II. Other significant conditi	ons contributing to de	eath but not re	sulting in the un	derlying cause give	en in Part I.	1 Yes	an 24b. We primed?	ute to the cause of death?  Probably 4 Unknown  ere autopsy findings available or to completion of cause of ath?  Yes 2 No
Division of Vital Relation of Vital Relation of Attending Physician: The rs after death  In Director: After this certificate led in by the funeral director, page	o Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 Natural 5 Pendi 2 Accident Inves	28a. Date of (Month, Date ing fd 12-	Injury ay,Year) 19–12	ER/Outpatient 28b. Time of Inju	DOA Ot 28c. Injury a	at Work?	28d Describe to subject car whice	ch struck	driver of a
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determ	not be mined (Specify)  ysician: To the best of	Majo	or Road/			Fairpla	y,MD.	or Rural Route Number, City ielman Rd.
To the How within 24 h To the Fun	Medical		niner: On the basis of e and manner state	xamination ar			eath occurred a		and place, and due	
C	-	30. Name and address of person v	•	,	,	O.C.M.	E.		December 1	9, 2012
Sta	100	Ana Rubio M.D., Ph. D  31. Date filed (Month, Par Year)		dical Exam		V. Baltimore S	treet, Baltin	nore, MD 21	223	
Regist	rar		(Con	we.	D. 100	100		·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month / 2 Physician/ Day FRANCES 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE MEDICAL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06 - 22 -Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours 1 🗆 M 2 🕱 F Min. Country) Director 72 578-52-7210 1940 Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Calvert Huntingtown 1 Yes 2 X No 9 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a Funeral 580 Carla Drive 20639 United States death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. o þ 1 Never Married 2 Married 1 Yes 2 👿 No Baltimore, Maryland 21215-0036 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: Year or Dates White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Public Schools Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Serowick Virginia Blackwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Thomas Narin, Jr. / Son 1657 Baltimore-Annapolis Boulevard, Arnold, MD 21012 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State injury or o 1 X Burial 2 Cremation 3 Removal from State Southern Memorial 4 Donation 5 Other (Specify)

Signature of Flourit Service vicens. Dunkirk, MD 12/17/2012 Gardens 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BREAST Immediate Cause (Final Physician/ LANCER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events tran and Due to (or as a consequence of) resulting in death) Last as the burialphysician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) Month Day Year should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an SEPTIC certificate has page 2 autopsy performed? Yes 2 No death? PERITONITIS 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 🙀 No Other: ၉ 1 🗷 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a To the Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) . Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 9th FLOR

Registrar DHMH 17 Rev 7/2009 Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. 8, 2012 Nowicki Dolores Maria Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7620 Maple Avenue Montgomery Takoma Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min 1 1 / 0 7 / 1 9 5 7 220-74-5574 55 Wash.,DC Director 1 🗆 M 2 🖾 F Yrs. 10a, State 10b. County 10c. City, Town or Location ural", or items 23a or 28a-f sho L'Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Takoma Park ¹X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20912 USA 7620 Maple Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. Yes 2 No 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed 3 Widowed 4 Divorced 27 Is marked other than "natu traumetic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 Is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 Mail sorter Handicap Center Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Mary T.Olmedo <u>Gerald J.Nowicki</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3225 Medway Street Silver Spring, Md. 20902 Anna Meadows/Sister other 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donatiop 5 □ Other (Specify) 12/17/2012 Silver Spring, Md Gate of Heaven 21. Signature of Funeral Service License PATALIP ADJERTMALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that causes the orath. Do not enter shock, or have failure. List only one cause on each the Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) erel Director: After this certificate has been signed by the ettending physician end filled in by the funeral director, page 2 should be detached for use es the burial framesit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day P.0. but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown . Were autopsy findings available prior to completion of cause of death? autopsy performed Yes 2 1 🗌 Yes Division of Vital 25. Was case referred to m Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 19 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) e Hospital or Attending PP 124 hours after death. e Funerel Director: After th 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29b. Signatur 29c. License numbe 29d. Date signe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll Avene Takoma Park, Md 20912 Nasreen M.Kango MD 7701 31. Date filed (Month, Day, EC 13 2012 State Registrar

12-09346 Ajia M. Owens

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 42910 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Month Day December 7, 2012 Medical Examiner 2212 hrs Ajia Owens 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) **Funeral** Foreign Wantyyland Director Months Days 213-43-9744 18 Oct 9 1994 1 M Usual Residence of Decedent 10a. State Oc. City, Town or Location 10d. Inside City Limits Anne Arundel Severn 1 Yes 2 X No Maryland Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she
injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8209 Stewarton Ct. 21144 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes 3 Widowed Divorced f Yes, Give Year Yes 2 X No specify: Black Specify: ğ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Ladys Footlocker 11th 0 Associate 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Patina Thomas Delbert Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patina Thomas (Mother) 8209 Stewarton Ct. Severn, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Metro Crematory 12-18-12 Baltimore, Md. 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 27 Menne and Addressed Facility Sons Mortuary, 1922 Forest Dr. Annapolis, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a Multiple Injuries Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED ied by the attending physician detached for use as the burial Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✓ Unknown 9 Unknown signed by the detacher Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>á</u> 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has performed' ✓ Yes 2 No 2 No 1 Yes the Hospital ar Attending Physician: 'hin 24 hours after death.
the Funeral Director: After this certificabletely filled in by the funeral director, I 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) æ examiner? Hospital: 1 ___ Inpatient 2 📝 ER/Outpatient 3 ___ DOA Other Nursing Home 5 Residence 6 Other: 1 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Dec 7, 2012 Pedestrian struck by auto 1 Natural 2139 hrs 5 Pending 1 Yes 2 🗸 No 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) Md Rt. 2 @ West Street, Annapolis, MD within 24 hours a

To the Funeral I determined (Specify) Major Road / Highway 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. December 8, 2012 8g 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month) Ecc 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

OCME 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certific	ate of	Death			Re	g. No.	0 1 1	L 4231
Physicia		Decedent's Name (First, Middle Dr. 1		D					Date of Deat Month	h Day Ye 13, 2012	ar	3. Time of Death 1912 hrs
ledical Exami	uer	Richard  4a. Facility Name (if not institution		Pottier		lb. City, Town, o	r Location o		ecember	13, 2012 4c. County	of Death	19121115
		Calvert Memorial Hosp				Prince Free		554		Calvert	0. 2000.	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last bir	thday)	If Under 1 Yes			. Date of Birt	h(MM/DD/YYY	y) 9. Birt	hplace (State or
Director		219-64-4651	<u>₹</u> X M 2 F	57	Yrs.	Months Day	ys Hours	Min.	arch 3	3, 1955	Cou	Washington D.C.
<b>à</b>		Usual Residence of Decedent		Ido- Oib- T							1	
w an		10a. State 10b. County		10c. City, Town		On						10d. Inside City Limits  1 Yes 2 Y No
ɗaryland 28a-f show any d at once	tor	Maryland Calve	ert	UW	ings	10f. Zip Code		_		og. Citizen of W	hat Cour	- 11
th the Maryland 23a or 28a-f sho notified at once	Director		1 ()			· · · · · ·			'`		nat ooa	, .
with the s 23a e noti		3419 Churchil	12. Was Decedent	Everin U.S.	13. Wa	20736 s Decedent of Hi		in? ( Specif	y Yes or No-	U.S.A.	e - Ameri	can Indian, Black,
leath v	Funeral	1 Never Married 2 X Ma	arried Armed Forces?	XX No	If Ye	es, specify Cuba	n, Mexican,	Puerto Ric	an, etc.)		e, etc.	
after o	by F	3 Widowed 4 Div	vorced If Yes, Give Year or Dates:	XX	1	Yes 2 X No	specify:			Specify:		White
136 hin 72 hours at e. than "natural		15. Decedent's Education (Spec				's Usual Occupa ost of working life				16b. Kind of B	usiness/I	ndustry
36 iin 72 han " dical ]	Completed	Elementary/Secondary (0-12)	College (1-4 or		uoin	aa Ouna	. 20			HVAC		
d with	Com	17. Father's Name (First, Middle,	, Last)	Б	usine	ess Owne		s Name (Fir	st, Middle, N	Aaiden Surname	e)	
215 be file ntal H rked o	Be (	Clarence Po	ottier				Ma	bel	Virg	inia ]	Burn	S
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. n 27 is marked other than umatic event, the Medica	ပ	19a. Informant's Name/Relations	hip (Type, Print )			Address (Stre						Zip Code)
2 7 2 7		Debra Pottier -	- Wife			Churchil			wings,	, MD 20 20c. Location		Town State
Baltimore, permit. Pages 1 ar Department of Hee mportant: If ite		1 Burial 2 Cremation	1 3 Removal from St	ate crema	tory or oth	er place)	,	Dec.			-	
timent trant:		4 Donation 5 Other Sp	pecify:	Ft. L		ln Cemet		201				Maryland
Bal permit Depar Imposi injury	2	21. Signature of Tun ral Service	Licensee		- 1	ame and Addres		ьee	Funera	al Home	Cal	yert, P.A.
Physician	_	23a. Part I. Enter the disease, or	complications that caused	the death. Do n		00 Jenni ne mode of dying					20736 eart	Approximate Interval
/Medical		failure. List only one cause Immediate Cause (Final disease	0.44aa1a4! -	Cardiovascu	ılar Dise	ease						Between Onset and Death
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Name of the second	<u> </u>	Sequentially list conditions,	b									
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760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED							Loo4 Data a	f delices	
6876 certificat nding ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor  1 Live birth			al death 3	Ectopic	pregnancy		23d. Date o Month		ay Year
Box 6 e death cer the attendi ed for use	sicia		4 Pregnant at	time of		ner (Specify)						
that the death certificated by the attending detached for use as:	Physician	Part II. Other significant conditi	9 Onknown	h but not resultin	ng in the u	nderlying cause	given in Pa	rt I	23e Did to	bacco use cont	ribute to t	the cause of death?
P.O.	þ	Turk in Other digital dank deficient	ione contributing to dead	ii bat not resum	ig iii tiic c	ndonymg oddoo	givoiriiri					ably 4 🗸 Unknown
rds, P.C requires that been signed	Completed								24a. Was a			topsy findings available
Records,  The law requir  frate has been si	mple				-			-	autop: perfor	med?	death?	ompletion of cause of
tal Reco cian: The law certificate has		25. Was case referred to medical	u T			26 Plac	e of Death (	Check only	lin_const	2 <b>V</b> No 1	Ye Ye	s 2 No
/ital sician is cert lirecto	o Be	examiner?	Hoopital	ent 2 🗸 ER/C	Outpatient		Other ₄	Nursing H		Residence 6	Other	:
of Vital Records ling Physician: The law requi After this certificate has been funeral director, page 2 should	$\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,Y	ırv 28b.	Time of Ir		ury at Work	? 280	d. Describe h	now injury occur	red	
On tendin cath. or: A	atior	1 ✓ Natural 5 Pend 2 Accident Inves		oar,		1	Yes 2	No				
Division rs after death.	iffice	3 Suicide 6 Coule	ld not be 28e. Place of In	ijury - At home, f	arm, stree	t, factory, office	building, etc	c. 28f	Location (S or Town, S		er or Ru	ral Route Number, City
Opital cours a neral	Certification:	4 Homicide	rmined (Specify)									
Division of Vital Records, P.O. Box 687.  To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Chicon Chi)	hysician: To the best of m miner: On the basis of exa									
To th withi To th	Medical	29b. Signature and title of certifie	and manner stated.	Thin determ and or			se number		-	29d. Date sign		
	-		1 19	, (			.M.E.			December		
<b>T</b>		30. Name and address of person	who completed cause of	leath (Item 23a)								-
dRW 2D		Melissa Brassell, MD	Assistant Medical	,	900 W	. Baltimore \$	Street, Ba	altimore,	MD 2122	3		
St	ate	31. Date filed (Month, Day, Year)	ry 0010 32. Registra	ir's Signature	1	west						
Regist	rar	UEG 1	7 2012 Dene	un pa.	1400	area.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Roland A. Plater, Sr. Month Day Physician/ 201 12:35AM Dec. 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Prince Frederick 4c. County of Death Calvert **Examiner** Calvert County Nursing Center 5. Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min 216-12-4372 91 Director 1 M 2 🗆 F May 9, MD 1921 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State Director MD Calvert Prince Frederick 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 3995 Dares Beach Road 20678 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 KNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+ School Bus Contractor Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Plater Florence Parker Earnest 19a. Informant's Name/Relationship (Type, Print)

Jonathan Plater/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12018 Fairway Court Glenn Dale, MD 20769 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 ■ Burial 2 □ Cremation 3 □ Removal from State 12/17/2012 4 ☐ Donation 5 ☐ Other (Specify) Holland Cemetery Huntingtown, 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final a Atheroscienotic Physician/ Carchiovas cular disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cardiovascular disease Hypertensive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the s signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Fibrillation Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Stage De mentia 24a. Was an has page 2 certificate 1 Yes 2 No Yes 2 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 ☐ Yes 2 🙀 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury Natural 5 Pending __ Accident Investigation completely filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) fan c. 50653 12-10-2012 ununa

dew 4+1 State

musch ton

32. Registra's Signature

GYAN C:

Roud

SURANA

Deale

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deale

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42913 State Registrar Reg. NoZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^D2012 Physician/ Month Dec. Terrence William Perkins 12, 0020A Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Casey House - Montgomery Hospice Rockville Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days **Director** 213-58-0963 1 🛛 M 2 🗆 F 62 Dec. 7, 1950 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Clarksburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 12729 Lewisdale Road 20871 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Vietnam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. Is marked other than "natural", 1 ☐ Yes 2 K No Specify: 3 Divorced Specify: Black Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ٩ Aaron Perkins Sr. Margaret Inez Dotson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a : If item 27 is 12729 Lewisdale Road, Clarksburg, Maryland Jackie Dorsey - Sister 20871 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Dunial 2 Dremation 3 Removal from State Metropolitan Crematorium 12/19, 4 Donation 5 Other (Specify) 1012 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ficate has been sig r. page 2 should b 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certifical letely filled in by the funeral director. **Division of Vital** Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$  Other (Specify) HOSPICE မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 To the F only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated are and/little of certifie 29b. Signat 29c. License number 12.12.12 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 Debrah Miller 6001 Muncaster Mill Road, Rockville, Maryland

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Mo.

Records.

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 1 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 Physician/ AMIES 6:35 AM PROCTOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BAZTOMORE BALTIMERE CITY UNIVERSETY OF MARYLAMO MEDITION UNTER My Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** oct. 29, 1923 Davs Hours 219-14-8431 **Director** 1 🕅 M 2 🗆 F 89 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Washington Hagerstown 1 ☐ Yes 2 X No 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 17313 Cloverleaf Rd. 21740 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. oľ þ 1 Never Married 2 Married 1 X Yes 2 194 If Yes, Give 194 Year or Dates 194 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Ith and Mental Hygiene.

27 is marked other than 'traumatic event, the Me life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Draftsman Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If Item 27 is marked to any injury or other traumationes. Ralph Alexander Proctor Elizabeth Barger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Tosadori-daughter 57 Byron Dr. Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Lawn Mem. Park 12-19-2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pouglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Inhecrene ! Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in module cause. Enter Underlying Cause (Disease or injury Examine Due to for as a nonsequence of burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown g Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 1 Tes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No nours after death.

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filled in by the fur 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 821354903 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REENE ALCASH GADANT 22 BAUTIMORE, MD 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 250 2012 0850 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Medical STOWN WOSHINGTON Mer, IUS Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours Min. J#n#189, 1932 Maryland 217-28-2443 80 Director 1 □ M 2 🖾 F nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arthment of Health and Mental Hygiene. arthment of Health and Mental Hygiene. ordent: If Hear 27 is marked outher than "naturely," or items 23a or 28a-f show injury or other traumatice of outher than "hattee Examiner must be notified at. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Directo 1 Yes 2 No Frederick Myersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3202A Ward Kline Road 21773 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XXNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Divorced 4 Divorced Specify. Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Educator Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leighton Harvey Lillian Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond A. Poffenberger-Husband 3202A Ward Kline Road Myersville, Maryland 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of I fimportent: If ite any injury or ot Hagerstown Crematory Dec.14,2012 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rickett Funeral Home 1 youM 504 Main Street Myersville, Maryland 21773 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Stage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy 2 No 1 🗌 Yes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{\text{Nursing Home}} \) 1 \( \text{Residence} \) 6 \( \text{\text{Other}} \) Other (Specify) 2 X No ၉ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Manth. Day, Year) D005307 30. Name and address of person who completed cause of death (Item,23a) (Type, Print) BASON M.O. Mosp Tols, aftico Mertis 31. Date filed (Month, Day, Year) 32. Registrar JAN 0 4 2013

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Registrar

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylann Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis	position			01.1	20b. P	lace of Disperentery, cre	osition (Nar	ne of	i	Date	orco,					own, State		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 ΡМ Helen Mary Reed 9:25 December 10, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** P.G. 5805 Queens Chapel Road Hyattsville Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NY If Under 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year March 15 1 🗆 M 2 🔀 F Min. 100 070-12-1877 **Director** Usual Residence of Decedent 72 hours after death with the Maryland 10a, State 10b, County "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD P.G. Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 USA 5805 Queens Chapel Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. marked other than "r natic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental III Important: If item 27 is marked off any injury or other traumatic even once. David Reed Margaret Hogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 706 Hankin Street, Silver Spring, MD 20910 Elizabeth Smith/Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Dec. 14, 1 Burial 2 ☐ Cremation 3 😾 Removal from State cemetery, crematory or other place) Calvary Cemetery Massena, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Progressive Cognitive Decline, Severe disease or condition Medical resulting in death) Examiner Alzheimer's Dementia, Severe Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed trans and Due to (or as a consequence of): resulting in death) Last burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as i attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year 5 Other (specify) Pregnant at time of death signed by the a Yes 2 X No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia of Chronic Disease, Failure to Thrive 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page death? 2 🔯 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director. Hospital: 2 XNo 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? Natural 5 Pending injury 2 Accident within 24 hours after death.

To the Funeral Director: A sompleted filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Dec. 12, 2012 D51122

State Registrar 30. Name and address of person who come Esmerando Juanitez,

31. Date filed (Month, Day, Year)

**DEC 13 2012** 

Registrar's Signature

bleted cause of death (Item 23a) (Type, Print), MD 1160 Varnum Street, NE, Washington, DC 20017

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ecein	imore	permit. Page 1 al Department of H Important: If itel any injury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	CE	lace of Disp emetery, cri ropol	ematory or	other plac		Da 12/12,	te /2012		ocation - o	-	own, State Virginia
Sec	Balt	permit. Depart Import any inj		21. Signature of Funeral Service License	Barle		- 1			ss of Facility	, Ro	y W. B ytonsv	arbe	er Fu	nera ryla	l Home and 20882
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		ysician: Ti is certificat director, p	Be	25. Was case referred to medical examiner?					26. Pla	ace of Deat	h (Check o	1 🗆 Yes nly one)	2 🗖 N	1	☐ Yes	2 □ No
	Ţ	S S	요	1 ☐ Yes 2 ☐ No H	ospital: 1 Inpatie		ER/Outpation			4 L Nu		e 5 🗆 Resid				)
oskir	Division of Vital	tending l Jeath. tor: After the funer	ificate	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day	Year)	injury	М			No	d. Describe h				
	Divis	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certificate:	4  Homicide determined	28e. Place of Inju building, etc	. (Specify)						City or Tow	ın, State	e) 		Route Number,
X		the Hos hin 24 ho the Fune mpletely	Medic	only one) 3 ☐ Certifying Nurse	er: On the basis of ex	amination	and/or inve	stigation, in	n my opinio	n. death oc	curred at th	e time, date a	nd place	and due	to the ca	use(s) and manner stated
4		To To t		29b. Signature and title of certific	MD	)		29	D 7	number 0241				te signed cembe		Day, Year) L, 2012
		12		30. Name and address of person who con Shanti M. Nadar,	mpleted cause of de	eath (Item :	23a) (Type, Old G	Print) Seorge	etown	Road	, Bet	hesda,	Ma	rylar	nd 2	20814
		Sta Registra		31. Date filed (Month, Day, Year) DEC 13 20	12 32. Registra	r's Signatu	A. A	bare	1							

24a. Was an autopsy

26. Place of Death (Check only one)

Other:

work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28c. Injury at

M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Yes 2 X No

28d. Describe how injury occurred

Nursing Home 5 Residence 6 Other (Specify)

2 🗌 No

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Lee Etta Harris Robinson 11,2012 5:10 Medical December D 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth (Month, Day, Year) 11/06/1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours **Director** 075-22-7624 1 🗆 M 2 🔀 F 84 eesburg, Va. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director P.G. Largo 1 🛚 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Largo Road 20774 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Force Black, White, etc Completed by 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2X No Specify: If Yes, Give Specify: Black 3 ₩ Widowed 4 Divorced Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse **Healthcare** 2_years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is marked any injury or any Lloyd Cross Jennie Grayson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rubin W. Harris/Son 6408 Tasajillo Trail, Austin, Texas 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Spacify) cemetery, crematory or other place) Ft. Lincoln Cem. 12/18/12 Brentwood, Maryland 2. Name and Address of Facility Henry S. Washington & Sons Co., Inc. 21. Signature f Fuller Service 4925 Burroughs Ave., N.E., Washington, Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition resulting in death) Gan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or consequence of) Exam and -tran Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death the 9 Unknown Linknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Eaton Syndrame 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician Medical Examiner

72 hours after

Maryland 21215-0036

Baltimore,

has page this certificate

P.O. Box 68760

Division of Vital Records,

Completed Be မ Certificate:

Medical

25. Was case referred to medical

2 X No

e and title of certifier

Biala

5 Pending

Investigation

determined

6 Could not be

Hospital

address of person who completed cause of death (Item 23a) (Type,

28a. Date of injury (Month, Day, Year)

examiner?

1 🗌 Yes

27, Manner of Death

1 Natural

Accident

Suicide

4 Homicide

29a. Certifier

29b. Signaru

(Check

or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Hospital

3,5M

State

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per FH G935 1/16/2013 JH State of Maryland / Department of Health and Mental Hygiene 2 0 1 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Dec. Physician/ 9:50а м 14. Hazel D. Richmond Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Caring Hands and Hearts If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 226-16-1162 Months 1 ☐ M 2**X**XF Country) 93 **Director** 30 Dec 1918 Virginia Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Bowie 1 K Yes 2 No MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15706 Peach Walker Dr. 20716 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Yes, Give 3xxWidowed 4 □ Divorced Specify: White Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) should be filed within and Mental Hygiene. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Martha Ellen Smith Joseph Draughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 15706 Peach Walker Dr., Bowie, MD 20716 Mary Martha Kuhn/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3XXRemoval from State Dec.18,2012 Salem, VA East Hill Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Fureral Service Lious 6512 NW Crain Hwy., Bowie, MD 20715 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 XXNo
9 Unknown Day Pregnant at time of death signed by the a d be detached for 9 Unknown P.0. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 X No Records, 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b completed filled in by the funeral director, page 2 si performed? Yes 2 X N 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 X No Other: 4 Nursing Home 5 Residence 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify Asst. Lvg. မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 XXNatural 5 Pending М 1 Yes 2 No Investigation 2 Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certification 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schiffman, MD 9613 Bellevue Dr. Bethesda, MD 20814 31. Date filed (Month, Day, Year) UEC 17 2012 State

DHMH 17 Rev 7/2000

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER Physician/ Harry Edward Randle Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE ARUNDEL Baltimore Washington Medical Center BURNIE GLEN If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 216-14-8579 Director 88 1 XM 2 □ F June 04,1924 Maryland Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits death with the Maryland or than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Carroll Mt. Airy 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8131 Bennett Branch Road 21771 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 🔀 Yes 2 🗆 No If Yes, Give 1942 Black, White, etc <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after RANDLE 1946 1 ☐ Yes 2 X No Specify. White Specify: Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Boat Builder Boating 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve Charles Albert Randle Elizabeth Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 North Drive Severna Park, MD 21146 Jeanne Reilly / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of December 19 20c. Location - City or Town, State 1 ☐ Burial 2 【☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. Baltimore, MD 2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 |495 Ritchie Hwy Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallace. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY Physician/ ANOXIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events attending physician and I for use as the burial-transif the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Lectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month signed by the at id be detached for 9 Unknown 9 Unknown Part II. **Other** si**gnificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 1 Unknown certificate has been sirector, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 ☐ Yes 2 🔀 N 1 ☐ Yes 2 🗷 No 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🔼 No ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 24 hours after of Funerel Direct determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place, and due to the cause(s) and manner stated the time, date and place are the time, date are the 29a. Certifier To the within 2 To the I complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 DECEMBER 14 2012 00061832 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE, GLEN BURNIE, MD 21061 JAIN 301 HOSPITAL State Registrar

12-0944	9
Michael	Ranke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

chael Ranke		1- For State	te of Maryland /		artment of rtificate of		and	Menta	al Hygi		21	)   2	420	32
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		4a. Facility Name (if not institution 9046 Town and Countr			1	lb. City, To Ellicott		ocation of I	Death		4c. County of Howard	Death		
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hours natur	ted t	15. Decedent's Education (Speci Elementary/Secondary (0-12)	fy only highest grade com  College (1-4 or 5		16a. Decedent during mo	's Usual O					16b. Kind of Bus	ness/Indu	istry	
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2121 ald be f Mental marker	To Be	Robert A. Ranke			19b. Mailing	Address				Johnse	n ber, City or Town	State 7i	p Code)	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPENDED	AMENDED											
876C ificate ig phys		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	e of preg		al death	3	Ectopic p	regnancy		23d. Date of d	lelivery Day	Year	
ox 6876 eath certificate attending phy for use as the b	sician/M	past 12 months?  1 Yes 2 No 9 Unkn	4 Pregnant at t	time of de		er (Specif					1	,		9
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6		30. Name and address of person was Carol H. Allan, MD A	tho completed cause of de ssistant Medical Ex			altimore	Stree	t, Baltim	nore, MI	D 21223				
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DHMH 17 Rev 1/2001 OCME 2006

OCME

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ING 21215-UU36  be filed within 72 hours after death with the Marylan Ital Hygiene.  And other than "nature!, or items 28a or 28a-1 show the chan".	4		Widowed 4	Divorced	Year or Da	ites:	-							Specify:		nite	
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Maryland 21215-0036 d 2 should be filed within 72 hours af th and Mental Hygiene. The marked other than "nature", or	<u></u>		nformant's Nam	e/Relationship (Typ	oe, Print)		19b. Maili	ng Address	s (Street a	nd Numbe	r or Rural	Route Numb	er, City	or Town, S	tate, Zip	Code)	
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VITAL RECORDS, P. sician: The law requires that certificate has been signed to		ŝ					<b>.</b>		3			1 🗆	Yes :	2 🗖 No 🔅	3 🔲 Prol	pably 4 🖭 Unkn	own
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pite purs erei			Certifier 1	Certifying Phys	ician: To the	best of my kn	owledge, deat	h occurred	d at the tim	ne, date an	d place, a	nd due to the	e cause(	s) and mar	ner as	stated.	
Ne Hoo	yeleny	29a.		Medical Examin		isis of examina											
To the within 2 To the			Signature and titl	le of certifier				29	c. License	number			29d. D	ate signed	(Month,	Day, Year)	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:52 PM George Randolph Robinson, Sr. Medical December 3013 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 236-62-7247 Usual Residence of Dec 1X M 2 □ F Yrs. 02/13/1943 69 W.V. or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 6 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 23a 21740 USA 111 Elm St. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. 1 ☐ Never Married 2 🙀 Married within 72 hours after ģ Maryland 21215-0036 1 Tes 2 No Specify. Yes Give Specify: 3 Divorced Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 th Truck Manufacturing Machine Operator of Health and Mental Hygie f item 27 is marked other r other traumatic event, <u>tt</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill treent of Health and Mental tant: If item 27 is marked မှ Douglas A. Robinson Grace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seldon M. Robinson / Wife 111 Elm St., Hagerstown, MD 21740 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematorium 12/20/2012 Smithsburg, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onsjet and Death Physician/ 00 disease or condition resulting in death) rev Medical Due to (or as a conuence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred al or Attending F s after death. I Director: After 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, duath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F within 2 29b. Signature and title of certifier 0523 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Waspen, MD 1126 ODAI ('our 31. Date filed (Month, Day, Yea State Registrar

12-09581 Kenneth Richards Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 10 State of Maryland? Departifient of Health and Mental Hygiene

		1- For Stata Registrar		tificate of Dea	th	oritar riys	Reg.	2012 No.	2 4292
Physici	an/	Decedent's Name (First, Middle,Last)					. Date of Death		3. Time of Death
viedical Exam	iner	Kenneth David Richards  4a. Facility Name (if not institution, give street and number)	Jr.	Táb Cita	Town, or Location		Month December 1	6, 2012 4c. County of Death	1050 hrs
		14004 Lower Town Creek Road		Oldt		on or Death		Allegany	1
Funeral Director		5. Social Security Number 6. Sex 7. Age  5. 7. 3. 0. 2. 2. 1 M 2 F  Usual Residence of Decedent	(In yrs. Ia	ast birthday) If Uni Mont		nder 24Hrs. ours Min.	8. Date of Birth(	Enrois	thplace (State or gn ^{suntry)} MD
*ny			10c. City,	Town or Location					10d. Inside City Limits
Maryland 28a-f show datonce	ក	MD Allegany	Fli	<del>intstone</del>	01dt	own			1 Yes 2 No
Maryl: 28a-f	Director	10e. Street and Number		10f. Zi	p Code		10g.	Citizen of What Coul	ntry?
th the 23a or ootifie	ΙD	14000 Lower Town Creek			1330	1555		USA	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a nr 28a-f sho natic event, the Medical E-aminer must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2  3 Widowed 4 Divorced If Yes, Give Year	_	If Yes, spec	lent of Hispanic C ify Cuban, Mexic 2 No spec	can, Puerto Ri		14. Race - Ameri White, etc.	ican Indian, Black,
urs afl tural'	d by	or Dates:  15. Decedent's Education (Specify only highest grade com	oleted)	16a. Decedent's Usua	I Decupation (Given	ve kind of wor		6b. Kind of Business/	
5 72 hours in "natur	ete	Elementary/Secondary (0-12) College (1-4 or 5	+)	during most of we	orking life. DO NO	OT use retired	d)		
OO3( within iene. er tha	Completed	12 4		Retired				Dept. of	Navy
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours ment of Health and Mental Hygene. I ant: If item 27 is marked other than "natur or nther traumatic event, the Medical E. son	Be	17. Father's Name (First, Middle, Last)  Kenneth David Richards  19a. Informant's Name/Relationship (Type, Print)	, Sr		Ge:	rtrud		den Surname)  or  Richa:  r, City or Town, State	
AD 2 2 shou 1 and N 27 is matic	To	John Richards, son						Myers, F	
e, h 1 and Health Fitem		20a. Method of Disposition		Place of Disposition (Na rematory or other place	me of cemetery,		•	Oc. Location - City or	Town, State
MOI Pages tent of int: If		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 D Other Specify:		ivateFami	•	12/	17/12	OLdtown,	
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or nither traumati		21. Signature of Furtiral Service Atensee		22. Name and	d Address of Fac	ility Sca	rpelli	Funeral	Home P.A
	N 177	23a. Panl I. Eyver the disease, or complications that caused t	he death	108 V	irginia	a Ave	Cum	perland,	MD 21502 Approximate Interval
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Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Compressional A			162				
	Ļ	Sequentially list conditions,							
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	juence of)	):					I
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60, ate be shysici e buri	Med	IF FEMALE: 23c. If yes, outcome	e of pregn	ancy				23d. Date of delivery	/
687 certific inding p		23b. Was decedent pregnant in the past 12 months?	ime of dea	2 Fetal death		pic pregnanc	у [	Month [	Day Year
Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unknown 9 Unknown	ine or dea	other (Spe	ecify)				
b, P.O. Box 687 ires that the death certification is signed by the attending the detached for use as t		Part II. Other significant conditions contributing to death	but not res	sulting in the underlying	g cause given in	Pan I.	1	cco use contribute to	
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cords law requii has been s	ompleted	•					24a. Was an autopsy	prior to c	topsy findings available completion of cause of
tal Rec	Con						performe 1 Yes 2	No 1 ✓ Ye	es 2 No
Vital Reco	Be	25. Was case referred to medical examiner?	. 2 .	ER/Outpatient 3 1	26.Place of Dea		· · · ·	sidence 6 🗸 Other	. Seana
ing Physic After this funeral dir	5	27. Manner of Death 28a. Date of Injury	v	28b. Time of Injury	28c. Injury at Wo	ork? 28	3d. Describe how	injury occurred	
ion tending eath.	tion	1 Natural 5 Pending 2 Accident Investigation	if)	0959 hrs	1 Yes 2	✓ No A	tree fell on to	op of the subject	l
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	3 Suicide 6 Could not be 28e. Place of Inju		me, farm, street, factor	y, office building,		or Town, State	e)	ral Route Number, City
lospita   hours   uneral		29a Certifier 1 Cortifier Physician To the best of my			e time data and			wn Creek Road, Ol	
To the Hos within 24 h To the Fun completely	Medical	(Check only 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of exam	_						
, is is	Me	29b Signature and title of certifier		29	c. License numb	er	2	9d. Date signed (Mor	nth, Day, Year)
71		him an			O.C.M.E.		] [	December 17, 20	)12
& Mr		30 Name and address of person who completed cause of de Ling Li, MD Assistant Medical Examiner	,	,	at Baltimara	MD 2422	)3		
	ate	31. Date filed (Month, Day, Year) 32. Registrar:			et, Daitimore	, IVID 2 1 2 2	-5		
Ponie		14 ALO 4 2012 A	4	Sa Keet					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ December 10. Douglas Smith Marvin 2012 1915 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days 550-92-3696 Director 1 X M 2 T F Nov 18, 1953 Missouri Usual Residence of Decedent ir than "nstural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Huntingtown Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20639 USA 2705 Ridge Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 a filed within 72 hours aftar tal Hyglane. od other than "nstural", o If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Dispatcher/Software Develor Law Enforcement permit. Paga 1 end 2 should ba filed with Dapertment of Haelth and Mental Hyglan important: if item 27 is marked other It sny injury or other traumatic event, Itha once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marvin Grier Smith Janet Marie Ogan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen J. Doran-Smith (wife) 2705 Ridge Road Huntingtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
St. John Vianey Cem. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Prince Frederick, MD 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Amanda M. Fraler 8200 Jennifer Lane Owings, MD 23a. Lent 1. Enter the disease, or continuations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or Injury Due to (or as a consequence of). attanding physician and I for use as tha burial-transit The law raquires thet the death cartificate be axacuted that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signad by tha at d ba datachad fi 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABET LS - HYPER UPIORAIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No HYPARTENSIAN 24a. Was an autopsy performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? fillad in by tha funarel director, Be of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending work? 1 ☐ Yes 2 ☐ No Division Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier complataly 29b. Signature and title of certifier D-620 20

State Registrar

drw

STANLEY J. WISNIEWSKI, MD-8191 JENNIFER LANE, OWINGS, MD 20736

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1, Decedent's Name (First, Middle, Last) 2. Date of Death Richard Wayne STOTTLEMYER ocembe 2012 2105 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 7. Age (In vrs. last hirthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 219-60-4928 1**X** M 2 □ F 57 April 19,1955 Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Penna. Franklin Greencastle 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 15367 Maryland Line Road 17225 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. rmed Forces? Black, White, etc. 1 Never Married 2 X Married If Yes, Give Year or Dates 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) kitchen design designer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ercy Theodore Stottlemyer Phyllis Ann Swisher 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Stottlemyer - wife 15367 Maryland Line Rd., Greencastle, Pa. 17225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 12/13/12 Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 Cara disease or condition resulting in death) Due to ( s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertension 1 ☐ Yes 2 ☐ No 3 💢 Probably 4 ☐ Unknown slipidemia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial nding physician Division of Vital Records, P.O. Box 68760 the use as for ed by the a been signed the should be det page 2 certificate After this

Examine Physician/Medical by Completed filled in by the funeral director. Be Certificate: To Medical

27. Manner of Death

1 X Natural

4 Homicide

29a, Certifier

(Check only one)

Accident Suicide

3

Physician/

Medical

10a. State

Examiner

**Funeral** 

**Director** 

works

28a-f

death

and Mental Hyglene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be 1

1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
item 27 is marked other than "natural", or other traumatic event, the Medical Examin

permit. Page 1 a
Department of H
Important: If ite
any injury or ott

Physician

Medical

Saltimore, Maryland 21215-0036

notified at

Director

Funeral

þ

Completed

Be

൧

within 24 hours after death.

To the Funeral Director: A completely JN-6 State

and tit

5 Pending

Investigation 6 Could not be

determined

D64402

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

1 ☐ Yes 2 ☐ No

occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 12/12/20/2

28f. Location (Street and Number or Rural Route Number

28d. Describe how injury occurred

City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of injury (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death

11110 Medical Campus Rd.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

injury

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Month Robert Allen Snowden, Jr. 1449 M Canbe 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) Director 202-52-1564 1 🕅 M 2 🗆 F 52 Jan 13 1960 Usual Residence of Decedent Maryland 28a-f show and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f shor raumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1X Yes 2 ☐ No Washington <u>Maryland</u> <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 441 North Potomac Street Apt. 21740 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married ģ 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Disabled</u> None Be pe filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Allen Snowden, Sr. Gloria Louise Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 Peggy Snowden - Wife Potomac Street, Apt. 13, Hagerstown, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 Department of Important: If it any Injury or o Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown Crematory 12/18/2012 Hagerstown, Maryland 21. Signature of Funeral Service Li 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a: Part 1. Enter the disease, or complication shock, or heart failure. List only one case that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to or as a consequence of) Examiner dosos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a conseque resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? page 2 should t Completed 1 ☐ Yes 2 ☐ No 3 ☐ robably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy within 24 hours after death.

To the Funeral Director: After this certificate performed death? Sere 1 Yes 2 No or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 \( \subseteq \text{Yes} Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 patient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No the Investigation 3 Suicide
4 Homicide 6 Could not be þ 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 12-09741

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Seung Jae Sung  4a. Facility Name (if not institution, give street and number) 13908 Bergenfield Drive  5. Social Security Number 20-33-9628  1	3. Time of Death 0736 hrs  Inty of Death gomery  YYYY) 9. Birthplace (State or Foreign Country)  10d. Inside City Limits 1 Yes 2 No  1 What Country?  2 d States lace - American Indian, Black, White, etc.
Seung Jae Sung  4a. Facility Name (if not institution, give street and number) 13908 Bergenfield Drive  5. Social Security Number 220-33-9628  1	nty of Death gomery  YYYY) 9. Birthplace (State or Foreign Country) Korea  10d. Inside City Limits 1 Yes 2 X No f What Country?  2d States ace - American Indian, Black,
13908 Bergenfield Drive   North Potomac   Monto	9. Birthplace (State or Foreign Country) Korea  10d. Inside City Limits 1 Yes 2 X No  f What Country?  2d States ace - American Indian, Black,
Director  220-33-9628  1 X M 2 F 22 Yrs. Months Days Hours Min. 01/14/1990  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Foreign Country) Korea  10d. Inside City Limits 1 Yes 2 X No f What Country?  2d States Lace - American Indian, Black,
220-33-9628   1   X   M   2   F   22   Yrs.   01/14/1990	10d. Inside City Limits 1 Yes 2 No  f What Country?  2d States lace - American Indian, Black,
10a. State 10b. County 10c. City, Town or Location	1 Yes 2 No  What Country?  2d States  Jace - American Indian, Black,
	f What Country?  ed States lace - American Indian, Black,
10g. Citizen of	ed States ace - American Indian, Black,
0 EE A 10000 m	ace - American Indian, Black,
13908 Bergenfield Drive 20878 Unite 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. R	
11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. R Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
3 Widowed 4 Divorced If Yes, Give Year or Dates:	110 2011
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of during most of working life. DO NOT use retired)	f Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Specify only highest grade completed)  16. Decedent's Education (Give kind of work of received)  16. Decedent's Education (Give kind of work of received)  16. Decedent's Education (Give kind of work of received)  16. College (1-4 or 5+)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surna	ollege _
Student  C 18.Mother's Name (First, Middle, Maiden Surna  To pure the design of the design	
Yun Ja Kim  Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or T	Town, State, Zip Code)
Won Ho Sung/Father 13908 Bergenfield Drive, North Pot	omac, MD 20878
The state of the s	on - City or Town, State
20a. Method of Disposition  1 Burial 2 X Cremation 3 X Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation 5 Other Specify:  21. Signature of Funeral Service Licenses  22. Name and Address of Facility  DeVol Funeral H	
Won Ho Sung/Father    13908 Bergenfield Drive, North Pot	
Physician 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or	heart Approximate Interval Between Onset and
failure. List only one cause on each line.  Immediate Cause (Final disease a. Methadone Intoxication	Death
or condition resulting in death)  Due to (or as a consequence of):	
sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Let cause. Enter Underlying Cause	
E (Disease or injury that initiated Due to (or as a consequence of):	
d.  AMENDED 23a,27,28a-f,per me,g935 1-9-13 sm  So of a graph of the state of the s	
Mended 23a, 27, 28a-f, per me, g935 1-9-13 sm	
Second of the	e of delivery h Day Year
4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown	
O = 2   Contribution   9   Unknown   9   Unknown   23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ontribute to the cause of death?
The state of the s	3 Probably 4 Unknown
24a. Was an autopsy performed?  1 V Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Nursing Home 5 Residence of Res	b. Were autopsy findings available prior to completion of cause of death?
1 ✓ Yes 2 No  25. Was case referred to medical examiner?  1 ✓ Yes 2 No  26. Place of Death (Check only one)	1 ✓ Yes 2 No
25. Was case referred to medical 26. Place of Death (Check only one)  examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other4   Nursing Home 5   Residence of Death (Check only one)	6 Other: Scene
The state of the s	curred
To be subject took of the	
Subject took    Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subject took   Subje	mber or Rural Route Number, City  18 Bergenfield Dr.
determined (Specify) Single Family Home  4 Homicide  4	Tr.
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man ending the state of the cause	
29d. Date s	er 23, 2012
30. Name and address of person who completed cause of death (Item 23a)	
Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Mooth, Day Year) 22. Registrar's Signature Registrar	

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hilip John Scha		1- For State	ate of Marylar		artment o		and Men	tal Hy	_	Reg. No. 21	112	1,293		
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)								Date of Death     3. Time of Death				
ledical Exami	ner	Philip J. So		Month Day Year 1133 hrs										
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 7915 Coriander Drive 4c. County of Death Gaithersburg Montgomery												
Funeral		5. Social Security Number	6. Sex 7					er 24Hrs.	8. Date of Bi	Birth(MM/DD/YYYY) 9. Birthplace (State or				
Director		220-48-9282	1X M 2 F	Months			ays Hours	Min.	May 2	Poreign Country DC				
		Usual Residence of Decedent												
nw any	10a. State 10b. County 10c. City, Town or Location										Inside City Limits  Yes 2 X No			
Aaryland 28a-f show 1 at once.	ţ	MD 10e. Street and Number	Montgomery	y	Gait	hersbur 10f. Zip Cod	<u> </u>		1	10g. Citizen of Wha				
rith the Maryland 123a or 28a-f shuw notified at once,	Director	7915 Coriander Drive, Apt. 203 20879 US								USA	, , , , , ,			
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland Ith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shu numatic event, the Medical Examiner must be notified at once		11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								o- 14. Race -	American Inc	dian, Black,		
or iter	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)							ican, etc.)	White,				
rs after	2	3 Widowed 4 Divorced if Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify N11												
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)								National Institutes				
036 rithin 7 sne. rr than	ם	12 Mail Clerk							of Health					
filed w Hygie d othe		17. Father's Name (First, Middle,					18. Mother	s Name (F	First, Middle,	Maiden Surname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	To Be	David Schaefe  19a. Informant's Name/Relationsh			19b. Mailin	a Address (St			Golds:	tein mber, City or Town,	State Zip C	ode)		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury nr other tranmatic event, the Medical Examiner		David Schaefer/			1					pring, MD				
re, rand land Healt		20a. Method of Disposition  1 Burial 2 Cremation	2 Pomoval from		Place of Dispos crematory or ot	sition (Name of	cemetery,		Date	20c. Location - C	ity or Town,	State		
Baltimore, sermit. Pages 1 at Department of Hec important: If ite		4 Donation 5 Other So	ecify:		ropoli		natory		. 23, 2012	Alexano	dria,	VA		
3alti ermit. Separtu mport		21. Signature of Funeral Service	Licensee		22.1 F r a	Name and Addr	ess of Facility COII	ins F	unera	l Home In	С			
Physician	$\dashv$	23a. Part I. Enter the disease, or	complications that cau	ised the death	. Do not enter t	Unive	rsity ] ng. such as ca	Blvd. ardiac or r	espiratory an	Silver Sp	ring,	MD 20901 proximate Interval		
/Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease a. Asphyxia												
Examiner		or condition resulting in death)  Due to (or as a consequence of):												
1	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
	틟	cause. Enter Underlying Cause (Disease or injury that initiated												
Bi Lie	Examiner	events resulting in death) Last  Due to (or as a consequence of):												
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Box 68760, a death certificate be the attending physicied for use as the burned for use		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, ou		ınancy					23d. Date of de	elivery			
lox 68760 cath certificate be attending physi	ia i	230. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy Month  4 Pregnant at time of death 5 Other (Specify)									Day	Year		
Box e death the atte	Physic	1 Yes 2 No 9 Unk	nown 9 Unknow	'n	J	iller (opeary)								
i, P.O. E ires that the d signed by the l be detached	by P	Part II. Other significant conditi	ons contributing to a	leath but not r	esulting in the i	underlying caus	e given in Par	rt I.		obacco use contribus s 2 ✓ No 3				
rds, F requires been sign	1											indings available		
performed?									priormed? dea	prior to completion of cause of death?				
Vital Rec ysician: The I his certificate director, page		25. Was case referred to medical	2 No 1 Yes 2 No											
Vita hysician this cer		examiner?  1 ✓ Yes 2 No	Hospital: 1 Inp	patient 2	ER/Outpatient		Other	1		Residence 6	Other: Scene	9		
n of \ding Phy	Ë	27. Manner of Death	28a. Date of (Month, D	Injury Jay,Year)	28b. Time of		njury at Work?	I_		how injury occurred		- 1		
ivisior  or Attend after death Director: d in by the	cation:	Natural 5 Pending Investigation Accident Pending Investigation Pen												
Divis	ertifi	3 x Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 7915 Co Gaithersburg, MD										er Dr.		
29a. Certifier (Check only)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause														
Division  To the Hospital or Attent within 24 hours after death  To the Funeral Director: completely filled in by the	edical	one) 2 Medical Exam	and manner star		and/or investiga			curred at the	he time, date	te and place, and due to the cause(s)				
3-A00	Σ										Date signed (Month, Day, Year)  ember 20, 2012			
	ļ	30. Name and address of person	with completed cause	of death (Ita-	232)		J. I¥I. ∟.		•••	December 2	U, ZUIZ			
		Russell Alexander MD		,	,	W. Baltimo	re Street, I	Baltimo	re, MD 21	223				
St	ate	31 Date filed Meric Day, Year 2	012 3. Regi	strar's Signa	are fact									
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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0935 AM VIRGINIA ALBERTA SULCER December Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) **Director** 212-50-9565 05/24/1948 MD 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Washington Rohrersville 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? the Medical Examiner must be Funeral items 23a USA 21779 20522 Townsend Rd. #C death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural", 3 Widowed 4 X Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Board of Education 12 bus driver and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ruth V. Leigh traumatic John L. Kelbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. P.O. Box 583 Purcellville, VA 20134 Jerri D'Angelo/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Brownsville Cemetery 12/15/2012 | Brownsville, MD of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1100 N. Maple Ave., Brunswick, MD 21716 23a. Part 1. Enter the disease of shock, or heart failure. Lis or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final MRSA Physician/ neumen.a disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and burial-tra Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 mont Dav Year Pregnant at time of death Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þ 1 Yes 2 No 3 Probably 4 Unknown nd 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2 : arter after death.

Director: After this certificate 1 Yes 2 No 1 Yes funeral director, 25. Was case referred t Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No filled in by the Accident Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 40061117 December 9 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MenTS Medica Daniel Francisco 31. Date filed (Month, Day, Year) 32. P. gistrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		St	tate o	f Marylan	•				and N	lental Hy	_	2.0	112	42932	
	-	Registrar  1. Decedent's Name	e (First Middle	l ast)			Cer	tificate	9 01 L	eain		2. Date of De		No. Z U	1 6	3. Time of Death	
Physicia		Clara						December 7, 2			)12°	8:25 PM					
Medic Examin		Clara J. Spain  4a. Facility Name (if not institution, give street and number)						4b. City,	Town, or	Location	of Death	1 - 0 - 0 - 1 - 1		4c. County			
		Citizens		Frederick						Frede	erick						
Funeral		5. Social Security N				ast birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.			8. Date of Bi	rth a <i>y</i> , Yea	ır)	place (State or Foreign try)				
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land f show		10a. State	10b. County		10c. Cit		10d. Inside City Limits										
Mary 28a-1 notifie	Director	Maryland	Washi		Boonsbo					1 ☐ Yes 2 🖾 No							
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ral	10e. Street and Nun			10f. Zip	Code 1713				10g. Citizen of What Country? United States							
ems 2	Funeral					dent Ever in U.	L				ecify Yes or No		14. Race - American Indian,				
ter de , or it	To Be Completed by F	1 Never Married 2 Married 1 7			rmed For	2 No	If Yes, specify Cuban, Mexican, Puerto				Rican, etc.)		Black, White, etc.				
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filed vial Hyg		17. Father's Name (	• =					Maiden Surname)									
uld be I Men narke natic		Benjamin Franklin Campbell  19a. Informant's Name/Relationship (Type. Print)						Beulah Adkins  19b. Mailing Address (Street and Number or Rural Route Number, City or Town									
2 sho th and 27 is r traun		Brenda Si			,			0	,							and 21713	
1 and if Hea item other		20a. Method of Disp	osition				Place of Dispo	sition (Nan	ne of			Date	1	. Location			
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permit. Departn Importa any inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home															
<u></u>		7	1500	jace	/	M01646								ck, Ma	aryla		
		23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death															
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												-			
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w requ	olete							24a. Was an autopsy findin autopsy prior to completion									
The lay ate hay page 2	Certificate: To Be Completed											perf	ormed	13/1	death?		
hysician: his certific al director		25. Was case referre examiner?		Hoonit	26. Place of Death (Check only one)												
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Atter er dea ector by th		3 Suicide 4 Homicide	not be	e 28e. Place of Injury - At home, farm, street, factory, office									reet and Number or Rural Route Number,				
ital or irs aft ral Dir lled in					building, etc. (Specify)						City or Town, State)						
Hosp 24 hou Funel stely fi	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner (check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to											e to the car	use(s) and manner stated.			
Fo the within To the comple	Ž	only one) 3 L Certifying Nurse Practitioner: To the best of my 29b. Signatura and title of certifier						knowledge, death occurred at the time, date and place, and of the street and place, and of the street are street at the time, date and place, and of the street are street as the street are street are street as the street are street are street as the street are str						29d. Date signed (Month, Day, Year)			
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		30. Name and addre	ess of person v		F	of death (Item	1 23a) (Type, F	Print)	-								
9		Henry S		450		gistrar's Signa	John	150n	DV	, F	red	evick		MIZ	217	102	
Stat Registra		o i. Date filed (IVIONT)	pring 1	3 2012		gistrar's Signa	d. A	back	1								
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State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate of	Death	Reg	i. No.	. 42300
Physici Medical Exami	an/	Decedent's Name (First, Middle,Last)     Philip Shultz			2. Date of Death	Day Year	3. Time of Death 1602 hrs
		4a. Facility Name (if not institution, give street an Tolly Point		b. City, Town, or Location of Dea Annapolis		4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 182–70–6400 1X M 2	7. Age (In yrs. last birthday) 23 Yrs.	If Under 1 Year If Under 24H Months Days Hours M	in. 01/31/1	Foreign	nplace (State or ntry) insylvania
nd how any	_	Usual Residence of Decedent  10a. State 10b. County  MD Anne Arundel	10c. City, Town or Location				10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number 181 Inverness Road		10f. Zip Code 21146	100	. Citizen of What Count	ry?
after death wi	d by Funeral	1 X Never Married 2 Married Arms	es 2 X No 1 1 grade completed) 16a. Decedent	Decedent of Hispanic Origin? (s, specify Cuban, Mexican, Puer Yes 2 No specify: s Usual Occupation (Give kind of	to Rican, etc.)  f work done	14. Race - Americ White, etc. Whi Specify: Whi	te
2 3	Completed	Elementary/Secondary (0-12) Collection 2	ge (1-4 or 5+) during mo	st of working life. DO NOT use n	etired)	Cooking	
MD 21215-0036 2 should be filed within 7 in and Mental Hygiene. 27 is marked other than umatic event, the <u>Medica</u>	Be	17. Father's Name (First, Middle, Last)  Jeffrey Shultz		Susan	^{ne (First, Middle, Ma} Fabiszak		
ages I and 2 should nt of Health and M i: If item 27 is ma	٩	19a. Informant's Name/Relationship (Type, Print Jeffrey Shultz / Fat)	her   181 ]	Address (Street and Number on Number of Number		er, City or Town, State,  Park, MD 21  20c. Location - City or T	
Baltimore, N permit. Pages I and Department of Health Important: If item injury or other trau		20a. Method of Disposition  1 Burial 2 Cremation 3 Remov  4 Donation 5 Other Specify:  21. Signature of Euperal Service Licensee	ral from State Metro Crem	natory, INC.	ember 15, 2012	Baltimore,	MD
		23a. Part I. Enter the disease, or complications th	490	me and Address of Facility ranco & Sons, Ritchie Hwy,	Seve.	rna Park, M	neral Home D 21146 Approximate Interval
Physician /Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease a. Drownin		- mode or dying, such as caldiac	or respiratory arres	t, shock, of flear	Between Onset and Death
•	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of);				
760, icate be executed physician and the burial - transit		events resulting in death) Last  d.  UNPENDED AMENDI	as a consequence or):				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	Physician/Medical	JF FEMALE: 23b. Was decedent pregnant in the past 12 months?	res, outcome of pregnancy ve birth 2 Feta	al death 3 Ectopic preg	nancy	23d. Date of delivery Month Da	ly Year
P.O.	Completed by Pr	Part II. Other significant conditions contributing	ng to death but not resulting in the un	derlying cause given in Part I.	1 Yes 24a. Was an		bly 4 Unknown
of Vital Records, ng Physician: The law require the christicate has been si meral director, page 2 should b	Compl				autopsy perform 1 ✔ Yes 2	ed? death?	mpletion of cause of
of Vital Recing Physician: The After this certificate uneral director, page	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No  Hospital: 1	Inpatient 2 ER/Outpatient		ing Home 5 R	esidence 6 🗸 Other:	Scene
sion of trending Ph death. ctor: After I y the funeral		1 Natural 5 Pending 2 Accident Investigation	late of Injury onth, Day Year) 12, 2012 28b. Time of Inj 1600 hrs	1 Yes 2 ✔ No		w injury occurred ed from Chesapea	ke Bay Bridge
Division  To the Hospital or Attendit within 24 hours after death. To the Funeral Director:  completely filled in by the fil	Certification:	4 Homicide Could not be determined (Spec	Place of Injury - At home, farm, street cify) Chesapeake Bay		or Town, Star Tolly Point, Ann	apolis, MD	
To the Hos within 24 h To the Fun completely	edica	(Check only one) 2 Medical Examiner: On the ba and mann	best of my knowledge, death occurre sis of examination and/or investigation or stated.	on, in my opinion, death occurred	at the time, date an	d place, and due to the	cause(s)
20		29b. Signature and title of certifier  August Authors, MA		O.C.M.E.		29d. Date signed (Mont December 13, 20°	
No offi			nt Medical Examiner 900	W. Baltimore Street, Bal	timore, MD 212	223	
St Regist		31. Date filed (Mon 1 24) Year 7 2012 32	Rigistrar's Signature	Kel			

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Amend #19a p			Please amend	Type or item 29 State of	Print in	doc	ck In g93 Depa	<b>delib</b> 5 1 – rtmer	le Inl	c. Ens	ure A	II Copie lental Hv	s Ar	e <b>Legi</b> l e	ble.		
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Medic	cal	4a. Facility Name (if not in	netitution give	DIVER				45 035	T	44:	-	Decem			0/2	2.4	7 M
Examir	ier	BALTIMORE 5. Social Security Number	= WASH	HNG-TON	MED		Con	-	. G		Bu	en le	1	C. County o	7 4)	RUNG	
Funeral Director		233-03-57	78 1	ΣΜ2□F	94					y, <i>Year)</i>	918   9. Birthplace (State or Foreign Country) Pennsylvania						
Marylend 8a-f shov	10a. State 10b. County 10c. City, Tow Anne Arundel Arm							City, Town or Location 10d. Inside City Li Arnold 1 Ves 25					•				
with the l	10e. Street and Number  965 Placid Court  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No								_	g. Citizen of What Country? JSA							
0036 urs after death urs!", or items						If Yes, specify Cuban, Mexican, Puerto Rican, etc.)											
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Baltimore, permit. Paga 1 and Depertment of Her mportant: if item any injury or othe anse.		1 ☐ Burial 2 📝 Cro 4 ☐ Donation 5 ☐	emation 3 🗆		State	tro (	ry, crema Crema	atory or o	other plac Y, I	NC.	2	ber 17, 012	Ва	ltimo	re,	MD	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours effector: After this cartificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ns?		Birth 2 ☐ F nant at time o	etal deatl		Ectopic Other (s _f	pregnanc pecify)	у				23d. Date Mont		ery Day	Year
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Registra	ar	050	4 . 20	·- 14		10.	7										

		-	For State Registrar		Cer	tificate of Deatl	h	Reg. No.		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) VICTORIA	' '	IMI		2. Date of De Month	1 Say	2012	3. Time of Death
	Examin	er	4a. Facility Name (if not institution, give str Anne Arundel Medic			4b. City, Town, or Location Annapolis		4c. Co	ounty of Death ne Aruno	iel
	Funeral Director		5. Social Security Number 6. Sex $214-50-5059$ 1 $\square$	7. Age (In yrs. la. M 2 7 65	st birthday) Yrs.	If Under 1 Year If Und Months Days Hour		ıy, Year)	Count	**
	or Jow	١	Usual Residence of Decedent  10a, State  10b. County	10c. City.	, Town or Lo	cation	July 1	6, 19	47 Mary.	Land Od. Inside City Limits
	//arylar 8a-f sl tified	recto	MD Anne Arur		ofton					1 ☐ Yes 2 🛣 No
	with the N 23a or 2 ust be no	Funeral Director	10e. Street and Number 1530 Endsley Place	9		10f. Zip Code 21114		10g. Citize	en of What Coun	try?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates.		Vas Decedent of Hispanic f Yes, specify Cuban, Mexi ☐ Yes 2¾XNo Spec	Origin? (Specify Yes or Nocan, Puerto Rican, etc.)		I. Race - America Black, White, e pecify: Whi	etc.
Maryland 21215-0036	in 72 hou e. nan "natu Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed)  College (1-4 or 5+)	(Give I life. Di	lent's Usual Occupation kind of work done during m O NOT use retired)			d of Business/Ind	
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Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition  1   → Burial 2   → Cremation 3   → Real A   → Donation 5   → Other (Specify)	CE	meterv. cren	sition (Name of natory or other place) Redeemer	Date 12/20/2012	i	ation - City or To	
Balt	permit. Departr Import any inji		21. Signature of Fundal Service Licensee	7		Name and Address of Fa	Beall F Hwy., Bowi			
	hysician/ Medical		2 Part 1. Enter to disease or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death cause on each line.  Due to (or as a consequence)	Do not ente		as cardiac or respiratory a			Approximate Interval Between Onset and Death
and the	Examiner		Conversion to the second disease	LTVER	erice oi).	DISEA	TSE		1	YONTHS
	ed sit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a conseque	ണ്ട് ഗ്).					
	ificate be executed g physician and as the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequent	ence of):					
8760	ificate b ig physic as the b	Medical	d.				-			
Box 6	cert ndir use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnar  1  Live Birth 2 Fetal  4  Pregnant at time of do  9  Unknown	death 3	Ectopic pregnancy Other (specify)		23	3d. Date of delive Month	ery Day Year
s, P.O.	To the Hospital on Attending Physician: The law requires that the death within 24 hours aft. Ideach.  In the Funeral Director feeth.  Completely filled in by the funeral director, page 2 should be detached for	ρ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cause given in P				e cause of death?
Records,	The law requate has beer page 2 shou	Completed						opsy ormed?		osy findings available mpletion of cause of
	ysician: The is certificate   director, pag	BeC	25. Was case referred to medical examiner?				Death (Check only one)	2 No	I L Tes	2 140
<u> </u>	Physic r this co	은	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐		ER/Outpatier 28b. Time of	ot 3 DOA Other: 4 D	Nursing Home 5 Res			)
ouo	ending Ph	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work? M 1 ☐ Yes 2	_			
Division of Vital	To the Hospital or Atten within 24 hours aft ir dea To the Funeral Di ector completely filled in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		eet, factory, office		Street and f wn, State)	Number or Rural	Route Number,
	Hospi 24 hou Funer etely fill	Medical	(Check 2 Medical Examine	ian: To the best of my knowler: On the basis of examination Practitioner: To the best of m	and/or invest	tigation, in my opinion, deat	h occurred at the time, date	and place, a	nd due to the cal	use(s) and manner stated
	To the within To the comple	Σ	29b. Signature and title of certifier	A SOCIAL CONTRACTOR OF THE DEST OF THE	DP.	29c. License number	1		signed (Month, I	
	240		30, Name and address of person who con	pleted cause of death (Item	23a) (Type, F	Print) FENSE	HWY ANN	APOL	IZ, M	1.21401
	Sta Registr	te	31. Date filed (Month, Day, Year) 7 201	32. Registrar's Signate		ake	11			-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dec. Day 2012 Year 12 3:21p Myles J. Scallan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12500 Kingsfield Lane Bowie Prince George's If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Aug. 30, 1928 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 537-28-3345 Director 1 X M 2 □ F Indiana Usual Residence of Decedent 28a-f show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George's Bowie 1 X Yes 2 □ No 10e, Street and Number ō 10f. Zip Code ral", or items 23a or Examiner must be r 10g. Citizen of What Country? Funeral 12500 Kingsfield Lane Bowie IISA 12. Was Decedent Ever in U.S. Arroed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3xxWidowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Federal Gov.-NSA Analyst event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည Thomas F. Scallan Margaret Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Sharon S. Przygoda/Daughter 1010 Summer Hill Drive, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dec.20,2012 Crownsville, MD MD Vet. Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Edneral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Gaquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Whitnown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 □ Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at After t 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No I Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide

within 24 hours after

To the Funeral Direct

completely filled in by

State Registrar

Medical

29a. Certifier (Check

31. Date filed (Month.

Certifying Nurse Practitione

DHMH 17 Rev 06-2011

cause of death (Item 23a) (Type, Print)

NTAM

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d Date signed (Month, Day, Year)

NNA POCISMO 21401

George Michael Scott **UNK UNK** 

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State of Maryland / Department of Health and Mental Hygiene 2012 42937 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day December 13, 2012 Year 0511 hrs **Medical Examiner** GEORGE MICHAEL SCOTT 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford 4153 U Way Havre De Grace 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 6. Sex **Funeral** Months Days Hours Director Country)ALABAMA 423-16-6457 1 X M 2 F 86 02/12/1926 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 X No is 23a or 28a-f show e notified at once. MARYLAND HARFORD HAVRE DE GRACE I. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygene.
reast: If item 27 is marked other than "natural?, or items 23a or 28a-f short or other traumatic event, the Medical Examiner must be notified at once Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4153 U-WAY DRIVE 21078 UNITED STATES Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year UNKNOWN 4 Divorced 1 Yes 2 X No specify: BLACK <u>۾</u> 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HUMAN RESOURCES SPECIALIST FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE SCOTT, SR Be LILLIE MAE HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ₩. LINDA SCOTT WRIGHT / DAUGHTER 2011 ARMOND LANE, SILVER SPRING, MARYLAND 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Pages
Department of
Important: I ATLANTIC CREMATORY 12/18/12 GLEN BURNIE, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility
LISA SCOTT FUNERAL HOME, P.A.
552 LEWIS STREET, HAVRE DE GRACE, 21. Signature of Funeral Service Licensee Scott-MD21078 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure, List only one cause on each line. /Medical Death a. Smoke Inhalation Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 Yes 2 ✔ No 3 Probably 4 Unknown 2 should be Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page certificate ✓ Yes 2 No 2 No 1 🗸 Yes : Hospital or Attending Physician: 24 hours after death Funeral Director: After this certifi 26. Place of Death (Check only one) director, 25. Was case referred to medica Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Mursing Home 5 Residence 6 🗸 Other: Scene DOA 1 Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Victim of housefire FOUND 1 Natural 1 Yes 2 ✔ No 5 Pending the Dec 13, 2012 0511 hrs 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide or Town, State) 4153 U Way, Havre De Grace, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E December 14, 2012 30. Name and address of person who completed cause of death (Item 23a) 7+IVA 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Registra

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**ORIGINAL** 

# William M. Stevens Baltimore, Maryland 21215-0036

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	Dharaini		1. Decedent's Name (First, Middle, Last)	2. Date	e of Death nth Da	y Year	3. Time of Death
	Physicia /Medic		WILLIAM MITCHELL STEVENS	Dec	EMBER	15 2012	-
	Examin	er	4a. Facility Name (if not institution, give street and number)	on of Death	40	County of Death	na)
$\vdash$	Funeral		o. Cocial Geodiffy (validation)	der 24 Hrs. 8. Dat	e of Birth	9. Birth	place (State or Foreign
	Director		467-40-7434 1X M 2□ F 91 Yrs. Months Days Hour	o7/	e of Birth onth, Day, Year) 27/1921	TE	EXAS
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Maryi Ff sho	tor	MARYLAND HARFORD ABERDEE	N			1 XYes 2 □ No
	th the	Director	10e. Street and Number 10f. Zip Code		10g. Ci	tizen of What Cou	ntry?
	ath wi		700 W. BEL AIR AVENUE, APT 429 21001			UNITED S	
	items items	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 ★ Yes 2 □ No	c Origin? (Specify Ye kican, Puerto Rican, k	etc.)	14. Race - Ameri Black, White,	
920	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show odical Examiner must be notified at	by	3 Mained 2 Mained If Yes, Give 1 □ Yes 2 No Spec	cify:		Specify: BI	ACK
21215-0036	hin 72 ho e. an "natur Medical	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during n	most of working	16b. K	Kind of Business/In	ndustry
121	withir ene.	Jup	Elementary/Secondary (0·12) College (1·4or 5+) ADMINISTRATIVE (	CLERK	F	EDERAL G	OVERNMENT
	filed Hyg ther int,	Be C		lother's Name (First,	Middle, Maider	n Surname)	
/lar	e d to	To B	JAMES B. STEVENS LII	LLIAN B. V	WILSON		
Maryland	2 sho and Is ma raum		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Nu.				
	s 1 and 2 should of Health and Mer item 27 Is marke other traumatic	- 55	DAVID M. STEVENS / SON 54 PEGASUS WAY, I	HAVRE DE (		.ocation - City or T	
altimore,			1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	12/21/12	2 A	BERDEEN,	MARYLAND
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee  22. Name and Address of Fa LISA SCOTT I 552 LEWIS ST	acility FUNERAL HO TREET, HAV	OME, P.	A GRACE, M	ARYLAND
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	î	Immediate Cause (Final disease or condition resulting in death)	edt			Onset and Death
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8760,	ficate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):				
	ficate g phys s the	edical	d				
Вох	eath certific attending p for use as	an/M	IF FEMALE: 23b. Was decedent pregnant in the cord 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deliv	· *
O. E	requires that the death certifi been signed by the attending hould be detached for use as	Physician/Me	in the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown			Month	Day Year
σ.	that the de ned by the a detached t	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I. 23	e. Did tobacco	use contribute to	the cause of death?
rds	w requires that s been signed t should be deta	ed by			1 ☐ Yes 2	2 □ No 3 □ Pro	bably 4 Unknown
eco	aw Is t	Completed		24	la. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u>~</u>	The ate h	Соп		1[	performed? □Yes 2 N	death?	2 No
V I	Physician: Th r this certificate ral director, pag	Be	examiner?	Place of Death (Chec		0 TO:: (-	
o	g Phy er this eral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at World	Nursing Home 5 28d. De	escribe how inju		ity)
ion	Attending r death. sctor: After by the fune	atio	2 Accident investigation M 1 Yes 2	2 □ No			
Division of Vital Records,	al or Att after de I Directe d in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		cation (Street a ty or Town, Stat	und Number or Ru te)	ral Route Number,
	To the Hospital or Attending Physic within 24 hours after death.  To the Funeral Director: After this co completely filled in by the funeral director.	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat a climate of the companient of the basis of examination and/or investigation, in my opinion, and manner stated.				
	To th Vithir Comp	Me	29b. Signature and title of certifier  29c. License numb	ber 2 7	29d. D.	ate signed (Month	, Day, Year)
	LIVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		ΛΛ	11/1/	10111
67	Sta	ta	31. Date filed (Month, Day, Year) 32. Registrar's Signature	NU /20	YTIV.	ynu 2	1014
	Registr		DEC 18 2012 > Jame A. Sare				

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42939 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 17 Rachel 20T2 3:00 P M Lennes Snyder Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Retirement Village Williamsport Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours Director 1 🗆 M 2 💢 F 218-24-1796
Usual Residence of Decedent 85 Nov.29,1927 Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 28a-f Hagerstown 1 Yes 2X No Maryland Washington ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 18022 Par Three Drive 21740 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2244 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ ō 1 Never Married 2 Married within 72 hours after 1 Yes 2XX No Specify Specify. "natural" 3 X Widowed 4 Divorced Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Nursing Assistant Medical Ith and Mental Hygier 27 is marked other turaumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Page 1 and 2 should be Humer Ola Williamson, Sr. Dorothey Margaret Zombro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25419 int of Health a t: If item 27 is or other train Wreatha Wageley - Daughter 64 Keepsake Drive Falling Waters, West Virgina 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 【XCremation 3 ☐ Removal from State Department or Important: If any injury or 4 Donation 5 Other (Spec Hagerstown Crematory Dec. 19,2012 Hagerstown, Maryland Signeture of Fineral Ser 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ MEUMONIA I WEEK disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** YSPHAGIA Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine PEMENTIA Cause (Disease or injury that initiated events resulting in death) Last ADV ANCED attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2: autopsy performed 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death

• Hospital or Attending Physician; The law requires that the death certificate be a 24 hours after cleath.
• Funeral Director: After this certificate has been signed by the attending the colorism. P.O. Box 68760 Division of Vital Records, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At completely filled in by the fu

Baltimore, Maryland 21215-0036

337 OU

28c. Injury at

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ARTIZAN

WILLIAMSPORT

State Registrar

Certificate:

Medical

1 XNatural

4 Homicide

29a. Certifier

(Check

only one) 29b. Signature and title

Accident Suicide

3

5 Pending

Investigation

determined

6 Could not be

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

egistrar's Signatu

12-09625 Andrew William	Sto	State of Maryland / Departin	nent of Health and Mental H			4294
		Registrar	cate of Death	Reg.	No.	
Physici Medical Exam			1 1	Date of Death     Month     D	av Year	3. Time of Death 0914 hrs
		Andrew William Stone  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	December 1	4c. County of Death	00141113
		86 Keithley Lane	Elkton		Cecil	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bi		<del></del> i '	MM/DD/YYYY) 9. Birth	pplace (State or
Director		221-74-7731   1XM 2 F   31	Yrs.   Months   Days   Hours   Mir	07/18/	1981 Cou	Delaware
,		Usual Residence of Decedent  10a. State 10b. County 110c. City. Tow				10d. Inside City Limits
and show any nce.		,				1 Yes 2 No
ryland <b>a-f sh</b> tonce	ţċ	Delaware New Castle News	10f. Zip Code	100	Citizen of What Coun	21
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	2 Mattai Iona	·	109.		
with t	ā	3 Mattei Lane 11. Marital Status 12. Was Decedent Ever in U.S.	19713  13. Was Decedent of Hispanic Origin? (S		United St	
death r iten	nue	1   X   Never Married   2   Married   Armed Forces?   1   Yes   2   X   No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after	by F	3 VVIdowed 4 Divorced if res, Give rear	1 Yes 2 No specify:		Specify: Whi	
hours fnatu	ted	15. Decedent's Education (Specify only highest grade completed) 16a  Elementary/Secondary (0-12) College (1-4 or 5+)	<ul> <li>Decedent's Usual Dccupation (Give kind of during most of working life, DO NOT use ret</li> </ul>		6b. Kind of Business/In	dustry
136 hin 72 e. than "	ple	12	Handyman		Construc	tion
5-0036 Iled within 72 hou Hygiene. I other than "nati	Completed	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		<u> </u>
21215-0036 auld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Thomas Stonebraker	Carol (			
D 2, should and Me	To		9b. Mailing Address (Street and Number or		•	Zip Code)
imore, MD 2 Pages I and 2 shou ment of Health and N tant: If item 27 is n or other traumatic			3 Mattei Lane, Newark of Disposition (Name of cemetery,		713 0c. Location - City or T	own State
iore, Nges land tof Health: Uitem		1 X Burial 2 Cremation 3 Removal from State crema	atory or other place) Dec	cember	ŕ	
Baltimore, permit. Pages 1 as Department of He. Important: If ite		4 Donation 5 Other Specify: Grace 21. Signature of Funeral Service Licensee		, 2012	New Cas	
Dep.		Donald & Hickory	103 W. Stockton		for Funer	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Medical xaminer	7	Immediate Cause (Final disease a. Narcotic ( metha	adone) Intoxication			Death
-3		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
	Examiner	C. C.				
uted d ansit	Ĕ	events resulting in death) Last  Due to (or as a consequence of):  d.				
executed ian and ial - transit	lical		a-f per me g936 2-27	-13 vt		
Records, P.O. Box 68760,  The law requires that the death certificate be icate has been signed by the attending physicit page 2 should be detached for use as the burit	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
687 certifi nding se as t	jan	Pregnant at time of death	2 Fetal death 3 Ectopic pregna	ancy	Month Da	y Year
30X death	ysic	1 Yes 2 No 9 Unknown g Unknown	5 Other (Specify)			
P.O. I s that the gned by ti		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I		cco use contribute to th	
S, P	d by			1 Yes	2 No 3 Proba	bly 4 🗸 Unknown
ord w requ	ig i			24a Was an autopsy	prior to co	psy findings available mpletion of cause of
Rec The la cate ha	Completed			performe 1 <b>V</b> Yes 2		2 No
Vital F ysician: his certifi director.	Be	25. Was case referred to medical examiner?	26.Place of Death (Check			
Division of Vital Records, rate or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the company of the funeral director, page 2 should the funeral director, page 2 should the funeral director.	유	1 ✓ Yes 2 No	Outpatient 3 DOA Other Nursin	ng Home 5 Res	sidence 6 🗸 Other:	Scene
on of ading Ph. th. The After to a funeral	<u>ë</u>	1 Natural 5 Ponding (Month, Day, Year)	1 Yes 2 X No	_	injury occurred	
iSior Attender death rector:	g	2 Accident Investigation 28e Place of Injury - At home of	d 8:00a   farm, street, factory, office building, etc.	unknown 28f. Location (Stre	et and Number or Rura	al Route Number, City
Divi	Certification:	Suicide 6 X Could not be determined (Specify) single fa		or Town State		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a Certifier 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and	due to the cause(s	) and manner as stated	l.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	Σ	29b. Signature and title of certifier	29c License number		9d. Date signed (Mont	
		Thoshow M. King JR, un	O.C.M.E. OGM	E	ecember 19, 20°	12
		30 Name and address of person who completed divise of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Exam	niner 900 W. Baltimore Street, B	altimore MD 2	1223	
S	ate					
Regist			Was			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Annie Month Mae Teeter 2012 3:05 December Medical Facility Name (if not institution, give street and number)
Carroll Home Care and Hospice **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Westminster Carrol1 Dove House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) South Carolina 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, cial Security Numbe 1–26–9492 7–24–0134 **Funeral** 1 □ M 2 **X**) F Days Hours Months Director anuary 14. 1925 Usual Residence of Decedent shov permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Direct Pennsylvania Franklin Waynesboro 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 17268 11708 Country Club Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify.White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Medica1 Register Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lema B. Gibbs William McDanie1 19a. Informant's Name/Relationship (Type, Print) , Page 1 and 2 shout Iment of Health and tant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tim Teeter (Son) 2203 Duker Ct., Baltimore, Maryland 21231 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State December 15, Pipe Cemetery Union Bridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 22. Name and Address of Facility
Lochstampfor Funeral Home, Inc.
48 S. Church Street, Waynesboro, Signature of Funeral Service license M-00849 Pennsylvania 23a. Part 1. Enter the disease, or complications that caused the o shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician 12 mentia disease or condition resulting in death) pars Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death?
1 Yes 2 No 24 hours after death.
Funeral Director: After this certificeted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 7 only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) IN-10 Sto-State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12th/09/2012 Physician/ A M Tinsley : 49 James Medical a. Facility Name (if not institution, give street and number) Hebrew Home of Greater Washington 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Min. 9/24/1917 1 🔀 M 2 🗆 F Months Hours DC 578-09-7141 95 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c, City, Town or Location 10a. State 10b. County with the Maryland be notified at Director 1x Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Numbe iral", or items 23a Examiner must be Funeral USA 20904 12508 Eastbourne Drive permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. The Marian E 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc Ukn þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 
Yes 2 □ No Specify: If Yes, Give Year or Dates Specify: Black 3

Widowed 4 □ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working US Postal Service life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fēderal Letter Carrier Government Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည Meredith Taliaferro Mary Tinsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11729 Janice Tinsley/Daughter 323 West 20th Deer Park, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 12/13/12 Washington, DC Rock Creek Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, 21. Signature of Funeral Service Licensee 3831 Georgia Ave. NW Washington, DC 20011 _cc0530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician Congestive heavit Medical resulting in death) Due to (or a consequence of) Examiner chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal gansi Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 - Fetal death in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death the g Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **neral Director:** After this certificate has been signed in filled in by the funeral director, page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1. Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one

31. Date filed (May

29b. Signature and title of certifier

A-Chilakamarri

C 1 4 2012

within 2 To the 1

6121 Montrose Rd

MD

MD:

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number D69568

Pockville

109/2012

MD 20852

		Pleas	se Type or Pri						Legible.	
		For State	State of Ma		partment of H		Mental Hy	ygiene į	2012	1 201.2
		Registrar  1. Decedent's Name (First, Middle,	l ast)	Ce	ertificate of D	<i>Death</i>	2. Date of D	Reg. No.	2012	42943
Physicia		Joseph Franc	,	ainor			Month Decemb	Day	$20\overset{Year}{12}$	3. Time of Death 12:11 P M
Medic Examin		4a. Facility Name (if not institution,		11101	4b. City, Town, or	Location of Deat	_		County of Death	12:11 P
		701 King Farm	Blvd. #237		Ro	ckville			Montgom	ery
Funeral		,		e (In yrs. last birthday	) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		irth la <i>y, Year</i> )	9. Birthpl Count	ace (State or Foreign
Director		128-14-8629 Usual Residence of Decedent	1 🛚 M 2 🗆 F	87 Yrs.			11/05			w York
land show d at	tor	10a. State 10b. County		10c. City, Town or I	_ocation			•	10	0d. Inside City Limits
Mary 28a-1 otifie	Director	Maryland Montgo	mery	Roc	kville					1 ☐ Yes 2 🗶 No
2 hours after death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at		10e. Street and Number			10f. Zip Code			10g. Citize	en of What Count	ry?
ath wi	Funeral	701 King Farm Bl		in the Late	2085			<u> </u>	ited Sta	
er dez or ite	by Fi	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 X Marrie</li></ul>	12. Was Decedent E Armed Forces? 1 X Yes 2 1		<ol> <li>Was Decedent of His If Yes, specify Cubar</li> </ol>	spanic Origin? (S n, Mexican, Puert	pecify yes or No to Rican, etc.)	12	<ol> <li>Race - America Black, White, e</li> </ol>	
ırs aft ııral", I Exar	edk	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	WW II	1 ☐ Yes 2 🔀 No	Specify:		S	pecify: Whi	te
"natu	plei	15. Decedent (Specify only highes			edent's Usual Occupa e kind of work done de		rkina	16b. Kind	d of Business/Ind	ustry
within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho is the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4 or 5- 5+	lifo	DO NOT use retired)				Military	7
permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.	اه	17. Father's Name (First, Middle, La	<u> </u>		Navy Cap		me (First, Middle			<del>/</del>
d be fi Aenta Irked tic ev	욘	Joseph P. Traino	or				eronica		,	
should and N is ma auma		19a. Informant's Name/Relationship		19b. Ma	iling Address (Street a	nd Number or Ru	ıral Route Numb	er, City or To	own, State, Zip Co	ode)
nd 2 sealth m 27		Celestine Q. Tra	inor/Spouse	701	King Farm	Blvd.	#237, Ro	ockvil	.1e, MD 2	20850
ge 1 a		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	3 X Removal from State		ematory or other place	· .	Date	1	ation - City or Tov	
iit. Pa irtmer irtant njury	-	4 Donation 5 Other (Sp			itan Crem.		12/2012	Alexa	indria, V	JA
permi Depar Impo any ir		21. Signature of Funeral Service Lice	M0/117		22. Name and Address DeVol Fune		Galfher	st Dee	er Parks	Drive,
		23a. Part 1. Enter the disease, or c shock, or heart failure. List on	omplications that caused ly one cause on each line	the death. Do not er					3321 14 2	Approximate Interval Between
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a_Pneumon							Onset and Death
Examiner		resulting in death)	Due to (or as a	consequence of):						
	ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
and II-t	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C. —							
e exectian ar		resulting in death) Last	Due to (or as a	consequence of):						
ate be ohysic the bi	<u>ğ</u>		d							
ath certificate be ex attending physician for use as the buria		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnancy						
eath c atten	iciar	in the past 12 months?		2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	′		23	3d. Date of deliver Month	y Day <b>Y</b> ear
the de	hys	9 Unknown	9 🗆 Unknown							
s that gned I	P. P.	Part II. Other significant condition		ut not resulting in the	underlying cause give	en in Part I.	23e. Did t	tobacco use	contribute to the	cause of death?
equires sen sig	ted	Coronary Athero	sclerosis				1 🗆	Yes 2 🗆	No 3 Proba	ably 4 🛣 Unknown
law re	nple						24a. Was	psy	prior to com	sy findings available pletion of cause of
: The cate It, pag							1 🗆 Yes	ormed? 2 🔼 No	death?	. □ No
Physician: The lav	m	25. Was case referred to medical examiner?	Hospital:		Othor	ce of Death (Che				
r this eral di	은 ::	1 Yes 2 X No 27. Manner of Death	1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 LI DOA	4 ☐ Nursing F	lome 5 A Resi 28d. Describe		Other (Specify)	
nding ath. r: Afte re fun	Certificate:	1 X Natural 5 ☐ Pending 2 ☐ Accident Investiga		Year) injury	work?	res 2 No	20d. Describe	now injury o	localied	
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ital or Irs aff ral Dii							City or To			
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burfar	Medical	(Check 2 L Medical Exa	hysician: To the best of naminer: On the basis of exa	amination and/or inve	stigation, in my opinion	, death occurred	at the time, date a	and place, ar	nd due to the caus	e(s) and manner stated.
o the orther orther omple		only one) 3 Certifying N  29b. Signature and title of certifier	lurse Practitioner: To the	best of my knowledg	e, death occurred at the	e time, date and p	place, and due to	the cause(s)	and manner as sta	ited.
12+1		1 (15)-	a and		D37				ber 12,	*
in.	-	On Name and address of source with	~ ~ /		р37	144		Decem	DEL 14,	2012

State Registrar

G. Coleman, MD, 1355 Piccard Drive, Rockville, MD 20850
31. Date filed (Month, Day, Year)

DEC 13 2012

DEC 13 2012

David Wayne Tunge	1- For State Certif	tment of Health and Mental H ficate of Death		2 42941	
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  David Wayne Tungett		Date of Death     Month Day Year     December 29, 2012	3. Time of Death 0654 hrs	
	4a. Facility Name (if not institution, give street and number) Harbor Hospital Center	4b. City, Town, or Location of Death Baltimore	none		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last 325-54-0098 1\overline{x}M 2\overline{x}F 56	Months Dave House Min	Fore		
the Maryland a or 28a-f show any tified at once. Director	Usual Residence of Decedent  10a. State	own or Location e.1 10f. Zip Code 20708	10g. Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No	
thours after death with the "matural", or items 23a Examiner must be notified by Funeral [	11. Marital Status  1 Never Married  2 Married  3 Widowed  4 Divorced If Yes, Give Yeer 1979-200 or Dates:	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)  14. Race - Am White, etc.  Specify: White work done  16b. Kind of Busines		
215-0036 be filed within 72 hour ntal Hygiene. rked other than "natuent, the Medical Exau	5+ 17. Father's Name (First, Middle, Last)		Navy (First, Middle, Maiden Surname)	<del></del>	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	1 X Buriał 2 Cremation 3 X Removal from State	19b. Mailing Address (Street and Number or 1 50 Clearview Ave., accept Disposition (Name of cemetery, matory or other place)  Ridge Cemetery 1/4, 22. Name and Address of Facility Be.	Portsmouth, RI 028 Date 20c. Location - City  /2013 Springfiel all Funeral Home	371 or Town, State	
Physician Medical Examiner	23a, Part I. Enter the disease, or complications that caused the death. D failure. List only one bause on each line  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	6512 NW Crain Hwy to not enter the mode of dying, such as cardiac of herosclerotic Cardiova	or respiratory arrest, shock, or heart	O715 Approximate Interval Between Onset and Death	
execul an and al - tra	d.  X UNPENDED  AMENDED 23a, 27, pe  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  d.  AMENDED 23a, 27, pe  23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of death 9 Unknown  contributing to death but not resu	2 Fetal death 3 Ectopic pregna	23d. Date of deliver	Day Year	
cords, P.C law requires that has been signed 2 should be deta npleted by	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2 No 3 Pr  24a. Was an autopsy performed? 1 Yes 2 No 1 V	autopsy findings available completion of cause of	
Division of Vital Rec spital or Attending Physician: The rours after death. neral Director: After this certificate filled in by the funeral director, page. Certification: To Be Con	1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	R/Outpatient 3 DOA Other Nursing Nursi	ng Home 5 Residence 6 Oth 28d. Describe how injury occurred 28f. Location (Street and Number or F		
Divisior To the Hospital or Attend within 24 hours after death within 24 hours after death completely filled in by the	4 Homicide determined (Specify)  29a. Certifier (Check only one)  Wedical Examiner: On the basis of examination and	, death occurred at the time, date and place, and for investigation, in my opinion, death occurred a	or Town, State)  I due to the cause(s) and manner as stat the time, date and place, and due to	ated. the cause(s)	
To the within To the comple	29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 2:	29c. License number O.C.M.E.	29d. Date signed (A	fonth, Day, Year)	
State Registrar	Jack Titus MD. Deputy Chief Medical Examiner  31. Date filed (MAT) Pa (1/21) 2013  32. Registrar's Signature	900 W. Baltimore Street, Baltimore	, IVID 21223 		
DHMH 17 Rev 1/2001	jerie pl.	ORIGINAL	00	A9E	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Savah Talia 2. Date of Death Month (2 Physician/ 14 Year Taliaterro 12:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 93 Director 1 🗆 M 2 🛛 F 229-26-5172
Usual Residence of Decedent Virginia Oct. 08,1919 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I health and Sae or 28e-f show tem 27 is marked other then "natural", or items 23e or 28e-f show other treumatic event, it e Maracal Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h Count Director Shacklefords **17**\D King and Oueen 1 ☐ Yes 2 🔀 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1978 York River Road 23156 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. <u>م</u> 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Cosmetology Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Lucy F. Lawson Alton L. Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 8 Melrob Court Apt. 4 Annapolis, MD 21403 Valerie D. Neal / Niece permit. Page 1 and 2 Department of Health Importent: If item 2: eny Injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Union Prospect Baptist
Church Cemetery 22 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🔀 Removal from State Shacklefords, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): 1 week Examiner Urinary tract infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transi Hospital or Attending Physicien; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by neart failure Congestive Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? COPD 24a. Was an page 2 s 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မူ 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 🔀 Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie lan MD D73920 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Parlavay 2001 Medical Anapolis MD Plan Hamcia

Registrar

12-09583 Larry Thompson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 42946

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Funeral Director		214-02-1161	6. Sex 7. Ag	ge (In yrs. last 47	birthday) Yrs.	If Under 1 You Months Da			th(MM/DD/YYYY) 9. t /1965	Birthplace (State or eign Country) MD
any.		Usual Residence of Decedent  10a. State  10b. County		10c. City, To	wn or Locati	on				10d. Inside City Limits
<b>≜</b> .,	ក	MD Anne	Arundel	Lot	chian					1 Yes 2 XNo
the Maryli 3a or 28a-f	Director	10e. Street and Number 26 Diane Dr.		•		10f. Zip Code 2071		1	0g. Citizen of What Co USA	ountry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 XXMa	1 Yes 2		If Ye	es, specify Cub	an, Mexican, Puer	Specify Yes or No to Rican, etc.)	White, etc.	
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5-0036 led within 72 Hygiene. other than '	Сошр	11	1		Disab	led				.bled
e, MD 21215-0036  I and 2 should be filed within 7  Health and Mental Hygiene.  item 27 is marked other than r traumatic event, the Medica	Be Co	17. Father's Name (First, Middle, Larry E. Thomps	·					ne (First, Middle, M line Coll	· ·	
212 212 2uld be 1 Ments mark ic ever	ToB	19a. Informant's Name/Relationsh		T	19b. Mailing	Address (Str			nber, City or Town, Sta	ate, Zip Code)
MD and 2 shoulth and in 27 is aumati		Geraldine Medli	n/Mother					Md. 207		
or Heal of Heal If iter		20a. Method of Disposition  1 Burial 2 Cremation	3 Removal from St	ate crer	matory or oth			Date	20c. Location - City	
Baltimore, permit. Pages 1 an Department of Hea Important: If itelinjury or other tri		4 Donation 5 Other Spe 21. Signature of Funeral Service L		Brins					Charlotte	Hall ,MD
Balti permit. Departm Imports		21. Signature of Funeral Service L	Sun	MOOS				ata, Md.		al nome, PA
Physician	7	23a. Part I. Enter the disease, or of failure. List only one cause of								Approximate Interval Between Onset and
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and assessed		or condition resulting in death)	Due to (or as a conse	equence of):						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence of):						
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Box 687 e death certific the attending p	Physician/	1 Yes 2 No 9 Unkr	9 Unknown		□ Oth	er (Specify)	The second secon			
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Division of Vital Records, tal or Attending Physician: The law requints after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed							autop perfor	sy prior to med? death?	completion of cause of
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Sion Attend or death rector: by the f	atic	Natural 5 Pendii 2 Accident Invest	igation I d I Z-I			pm	Yes 2 X No	unknown		
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hou hou y fill		29a Certifier	ysician: To the best of m			ed at the time,	date and place, ar	Lothian  Ind due to the caus		ated
To the Host within 24 h To the Fur	Medical		niner: On the basis of exame and manner stated.	mination and/o	or investigation	on, in my opinio	on, death occurred	at the time, date	and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier	-				nse number		29d. Date signed (N	
		and the			- \	0.0	C.M.E.		December 17,	ZU   Z
		<ol> <li>Name and address of person v Ling Li, MD Assistan</li> </ol>	who completed cause of d nt Medical Examine			e Street, Ba	Iltimore, MD 2	1223		
Sta	-	31. Date filed (Month, Day, Year)	2. Registra	r's Signature	Lad	,				<del></del>
Registr	r: [7	10 N H 4 7H	11.5 /1/4		ALC: No					

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical Nelson Angelo Turner 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Director 217-32-5966 1 🕅 M 2 🗆 F 75 Sept. 13 1937 Maryland Usual Residence of Dece 27 is marked other than "natural", or items 23a or 28e-f show traumetic event, the Medical Examiner must be notibed at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Marvland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral .4614 Cearfoss Pike 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XI Yes 2 □ No If Yes, Give Year or DatesI 955–59 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Black, White, etc. <u>م</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 0 Journeyman Machinist Truck Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carlton J. Turner Vera Alma Faith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 end 2 sh it of Heelth ar If Item 27 is Linda Turner - Wife 14614 Cearfoss Pike, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 e
Department of H
Importent: If Ite
eny Injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 12/20/2012 Clear Spring, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home Hagerstown, Md. 21740 Wilson 23a, Part 1. Enter the disease Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Do not enter the mode of dying such as cardiac or respiratory arrest, hat caused the Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine for as a consequence of or Attending Physician: The law requires that the death certificete be executed be detached for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the ettending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death Month ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospitel or Attending Physician: The law require within 24 hours after death.

To the Funeral Director. After this certificate has been si To the Funeral Director. After this certificate has been si Completely filled in by the funeral director, page 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manne of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Hedical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier ted cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nube del Carmen Vilchez Medical 4a. Facility Name (if not institution, give street and numb 4b. City Town, or Location of Death 4c County of Death **Examiner** SDU OM 2 C If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) cial Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 08/04/1944 Days Country) Nicaragua 593-25-7994 68 Director 1 □ M 2 🖺 F Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Salisbury Md Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21801 Nicaragua 520 Winder St 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No 1灯 Yes 2□No Specify: Nicaragua Specify: Hispanic 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Baby Sitter 12th. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Antonia Meynard Alejandro Meynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Apolinar/Daughter 520 Winder St. Salisbury Md. 21801 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) 12/20/12 General Cemetery Nicaragua 21. Sig Nure of Funeral Service Licer 22. Name and Address of Facility John T. Rhines Funeral Home Bai 3005 12th. St. NE Washington D.C. 20017 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Helasbalio Orania disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): s the buria transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Cause (Disease or injury that initiated events ettending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? page 2 should be detached for 5 Other (specify) the g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, is 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital No De 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of/certifier 29c. License number 12/12/12 063199 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN VOHRA SALISBURY MO PGESH SHORE

State

Registrar

31. Date filed (Month, Day, Year)

DEC 1 4 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6 2012 Year Physician/ Month  $\mathbf{A}^{\mathsf{M}}$ Elva Vaughan Dec. 4:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home of Greater Washington Rockville
If Under 1 Year | If Under 24 Hrs. Montgomery 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Hours 1 D M 2 1 F Days 8 123 74 912 Virginia 577-48-4207 100 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Chevy Chase Montgomery MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20815 3215 Park View Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 √2 No Specify. Specify: Black ¾ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Service Employee Private Industry Be ( 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Clade Permelia V. Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Permelia C. Beavers/ 3215 Park View Road Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🖺 Burial 2 🗌 Cremation 3 🗆 Removal from State 12/13/12 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee tolonea cc0530 3831 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardic or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Supportfolly list out officers Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant a Pregnant at time of death Other (specify) be detached signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate has 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 **N**0 ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1-Natural injury work?
1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 1953PM cone 10 12 Medical 4a. Facility Name (if not institution, give street and number)
Calvert Memorial Hospital 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 222-07-9188 Director 1 X M 2 □ F 90 DE Jan.23,1922 show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director ems 23a or 28a-f sh r must be notified a Huntingtown 1 Yes 2 No MDCalvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5221 Cherry Hill Road 20639 USA Page 1 and 2 should be filed within 72 hours after death with "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces?

1 XYes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3X Widowed 4 □ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) life, DO NOT use retired. Elementary/Secondary (0-12) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Williams Harvey Etta С. Cramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 157 Sunderland, MD 20689 Annette L. Williams/daug. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. Gard.Cem.12/17/2012 Dunkirk, MD 22. Name and Address of Facility Sewell Funeral Home, P.A. 21. Signature of Funeral Service Licensee Dladen 1451 Dares Beach Rd. Prince Fred., MD20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 00000 Leave Medical resulting in death) Due to ( as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician the dorna Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061783 30. Name and address of person who con pleted cause of death (Item 23a) Type, Print) Prince Frederick, MD 20678

DHMH 17 Rev 06-2011

State Registrar Chang Choi, 31. Date filed (Month, Day, Year)

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death nt's Name (First, Middle, Last) 2. Date of Death Physician/ Month 5:30 Medical 4a. Facility Name (if not institution, give stree 4c County of Deat Examiner 4b. City, Town, or Location of Dea enesis everna ark If Under 1 Year If Under 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hrs. **Funeral** (Month, Day, Year) 2-20-1910 1 □ M 2 🗓 F Days Hours Mary Land 101 Director 216-09-1803 Usual Residence of Decedent show 10a. State 10b. County with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🏋 No MD Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2014_Kurtz Avenue 21122 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. 3 X Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cosmetics Salesperson Cosmetics Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ injury or other traumatic Peter Anschutz Lydia Robinson permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane S. Kaeding, Niece Kurtz Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 12/27/2012 Pikesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Homes any CleanB 8325 Mt. Harmony Lane, Owings, M00715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one caus Harvelerst. Immediate Cause (Final Onset and Death Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that in listed as or lingury Examine Due to (or as a consequence or). b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director. After this certificate has been signed by the attending physician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 21 No Month Day Year signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Demention Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? page 2 2 No 1 🗌 Yes 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No ္မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the l within 2 To the F only one 29b. Signature and title of certifie signed (Month, Day, Year) 29d. Date 10 2012 (84-31

15M2

State Registrar 30. Name and address of

person who

poleted cause of death (Item

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 11:05 AM 2072 Catherine Louise WHORTEN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Reeders Memorial Home Boonsboro Washington If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, 1 Year 936 1 □ M 2 🏋 F Days Min Maryland Director 217-30-6379 76 June Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 335 Central Avenue 21740 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 3 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 0 Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Foerster - Daughter 655 Featherbed Lane, Hedgesville, W. Va. 25427 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from Sta 4 Donation 5 Other (Specify) 12/19/2012 | Hagerstown, Maryland Cedar Lawn Mem. Park 21. Signature of Free al Service Libense 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, och line. 23a. Part 1. Enter the disease, or co no lications that shock, or heart failure. List only ne cause on Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) remort Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to for as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPP 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifler 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

(Check only one)

Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

X

wand

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0032518

29d. Date signed (Month, Day, Year,

29c. License number

Keedysville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 42953 State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death December 16, Physician/ 2012 3:08 P M Edward Joe Warner Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Washington 1040 Valleybrook Dr. Hagerstown Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 1 X M 2 □ F **Funeral** Days Sep. II. 1928 Hours 381-26-6929 Director Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington 1 Yes 2 No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 U.S.A. 1040 Valleybrook Dr. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent Ever III o. Armed Forces?

1 X Yes 2 7 946—
If Yes, Give 1949 Black White etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 XWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Field Engineer City Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edna Sisson Joseph Edward Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 Antietam Dr. Hagerstown, MD 21742 Donna Walchshauser-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park | 12-20-2012 | Hagerstown, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Supply of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immed cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practioner To the best of my knowledge, 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) D0068995 2012 address of person who completed cause of death (Item 23a) (Type, Print) Haperstown, nad 21740 4019

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12/10/2012 ANTOINETTE WELLINGTON 5:19 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Oxon Hill 1305 Brookside Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Funeral Age (In yrs. last birthday) 8. Date of Birth Hours Min. (Month, Day, Year) 579-82-3882 Director 48 1 M 2 X 1/28/1964 NC Usual Residence of Deceden 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
i item 27 is marked other than "natural", or items 23a or 28a-f shorother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗌 No MD Prince Georges Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1305 Brookside Drive 20745 TISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 yrs yrs Patient <u>Care Coordinator-NIH</u> Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Willa M. Williams <u>William Wellington.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willa M. Evans/Mother <u> 1305 Brookside Drive. Oxon Hill MD 20745</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o ₽ 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 4 ☐ Donation 5 ☐ Other (Specify) 12/22/2012 Silver Spring 22. Name and Address of Facility Snowden Funeral Home 21. Signatur of Funeral Service Licensee 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final vears Physician/ disease or condition Metastic breast cancer Medical resulting in death) Due to (or as a consequence of) Examiner Brain metastases <del>years</del> Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): within 24 hours after death.

To the Fuperal Director: After this certificate has been signed by the attending physician and component filling in by the funeral director, page 2 should be detached for use as the burgh-transit the Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2**X** No Yes 2 XNo 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: Certificate: To 1 🗌 Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined cal 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tible of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 12-11-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Linda Burnell, MD, 2730 University Blvd #900, Wheaton, MD 20902 31. Date filed (Mapth, Day, Year) 82. Registrar's Signature State 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Douglas Wilson State of Maryland / Department of Health and Mental Hygiene 2012 42955 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day December 19, 2012 1915 hrs **Medical Examiner** Douglas M. Wilson 4a. Facility Name (if not institution, give street and number) 4b City Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Months Days Hours Director October02.1985 27 Country)M) 213-15-2874 1 M 2 F Vrs Usual Residence of Decedent 10c City Town or Location 10d. Inside City Limits 10a State 10b Count s 23a or 28a-f show a 1 X Yes 2 No Glen Burnie MD Anne Arundel ies 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. rector 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. ō 1757 Arrowood Drive 21054 13. Was Decedent of Hispanic Origin? ( Specify Yes or No. 14 Race - American Indian, Black, 12, Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White etc. 1 X Never Married 2 Yes Specify: White 1 Yes 2 No specify: 4 Divorced If Yes, Give Year 3 Widowed \$ or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) andscaping Contractor 10th 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Carolyn Wilson (Meador) Be Fred M. Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carolyn Wilson/Mother 1757 Arrowood Drive Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Pages 1 t: If i Buriat 2 X Cremation 3 Removal from State 12/24/2012 Waldorf, MD Huntt Crematory Donation 5 Other Specify: 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licenses 116000 Annapolis Road Bowie, MD 20715 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Complications of Opiate Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause: Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and trans Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g935 1-9-13 sm X UNPENDED attending physician or use as the bunal The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of deliver IF FEMALE 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown certificate has been signed by the ector, page 2 should be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Þ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive Cardiovacsular Disease; morbid Obesity Completed 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other Hospital 1 Inpatient 2 ✔ ER/Outpatient 3 After this 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death 1 Natural subject took drug 1 Yes 2 X No Director: fd 12-14-12 unk 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide vehicle parked or Town, State) unknown (Specify) 24 hours a Funeral 1 determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. December 20, 2012 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 31. Date filed (Month, Day Year) 2013

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

DONAF

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Elizabeth Weems 6:53 PM December 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death timore washington medical cente Glen Anne Arunde Funeral 7. Age (In yrs. last birthday) _If_Unde If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Ye Months 214-44-5209 **Director** 1 □ M 2 **X** F 82 1929 Dec Usual Residence of Decedent other than "natural", or items 23a or 28a-f show rent, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7917 Bent Bough Rd. 21144 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Specify: **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Learning Tree Elementary/Secondary (0-12) 12th College (1-4 or 5+) Child Care Provider Day Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked any injury or other traumatic any once. Edward Jenkins Olivia Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trishia Thorpe(Daughter) 313 Bloomsbury Square Annapolis, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State Metro Crematory 12-17-12 Baltimore, Md. 4 Donation 5 Other (Specify) Mane ah aasa f Pallit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or Injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes the Hospital or Attending Physician: thin 24 hours after death. To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certili 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tsion Berhane RALTMONE WASHINGDON MEDICAL gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Deems,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 42957 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolitan Assisted Living Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Hours Min (Month, Day, Year) 301-44-5359 Director 1 □ M 2 🗓 F 62 Jan. 19,1950 Pennsylvania 1 end 2 should be filed within 72 hours after death with the Maryland of Health and Mantal Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumetic event, the Medical Examiner must be retified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Arnold 1 ☐ Yes 2 🕅 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 603 Oakland Hills Court Apt. 202 21012 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ፩ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hankey Sally Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold, MD 21012 Sara Wenger / Daughter 105 Bosun Road 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State parmit. Paga 1
Depertment of Important: If it eny Injury or o December 15 cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2012 Baltimore, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, 495 Ritchie Hwy, P.A. Severna Park Funeral Home Severna Park, MD 21146 23a. Part 1. Inter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): peta has been signad by tha attanding physicien and paga 2 should be datachad for use es the buriel-trensit or Attanding Physician: The lew requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attanding Physician: Tha lew within 24 bours after death.

To the Funeral Director Attar this cartificeta has completaly filled in by the funerel director, page 2: autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best or now ledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month (Day, Year) 38 Demkle (420/2 ED

Registrar

Defense

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Year 612 4a. Facility Name (if not institution, give street and number) Medical 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ANNAPOLIS ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) Director 218-76-1571 55 1X M 2 □ F 9/15/1957 WASHINGTON, DC Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director ANNE ARUNDEL LOTHIAN 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 810 RUSTIC LANE 20711 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

Yes 2 No þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: WHITE Completed 3 Widowed 4 Divorced Year or Date 1974-1980 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th INFORMATION TECHNOLOGY INFORMATION TECHNOLOGY 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည JOHN F. WILSON MARY ELLEN QUILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 i JOAN GIGLIOTTI/SISTER 6114 DRUM POINT RD. DEALE, MD 20751 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Important: I any injury o VETERANS 12/17/2012 CROWNSVILLE, MD ETERY
HELVER and address of Facility LASTING TRIBUTES BY FELLOWS HELVER BY FELLOWS 12 FER BELLOWS 14 BESTGATE RD. ANNAPOLIS, MD 21401 21. Signature Fur eral Service License nefications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Part 1. Enter the disease, or co shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Liver wagulo Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cepah that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier DO069449 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2001 MEDICAL PAPICISAY

ANNAPORIS MB 21401

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Judith Ann Wagner 0:44 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 215-42-3011 Director 1 □ M 2 🔀 F 70 Vrs May 5,1942 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at another. 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits Maryland Washington Williamsport 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16516 Tammany Lane 21795 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrator Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lester Clint Davis Wanda Alberta Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roderick J. Wagner - Husband 16516 Tammany Lane Williamsport, Maryland 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Greenlawn Mem. Park Dec.24,2012 Williamsport, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Osborne Funeral Home, B.A. 425 S. Conococheague St.Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Hypertension Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). signed by the attending physician and deed detached for use as the burial-transit Physician: The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ effusion this certificate has been si ral director, page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dyslipidemia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Hyper tension perform 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ည 1 Inpatient 2 PER/Outpatient 3 IDOA 27. Manner of Death s after death. I Director: After t Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No To the Hospital or Attending 28d. Describe how injury occurred Natural 5 Pending injury ☐ Accident Investigation 6 Could not be 3 Suicide in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft To the Funeral Dis completely filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066288 0 2 201 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williamsport MD lania Crussigh 3Byrkit 21795 31. Date filed (Month, Day, Year) State istrar's Signature Registrar

Physicia		State Registrar  1. Decedent's Name (First, Middle, Las	0	Certifica	ate of L		2. Date of De	Reg. No	).	3. Time of Death
Medic	al	HUUDUN Trac	7	7660			DECE	MΒ	ER 162	
Examin	er	4a. Facility Name (if not institution, give THE JOHNS 110	PKINS HOS	PITAL	3AC	Location of Death	ECITY		. County of Dea	ath
Funeral Director		5. Social Security Number 6. Sec. 227–11–4433 1 Usual Residence of Decedent	7. Age (In yrs. la □ M 2 🔏 F 51	ast birthday) If Un Montl Yrs.	der 1 Year ns Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da December	th ly, Year) 1 30,	9. Bi	irthplace (State or Foreigr ountry) ermany
or 28a-1 show rottfled at	ector	10a. State 10b. County		y, Town or Location	nira					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
23a or 28 at be roti	Funeral Director	10e. Street and Number  16 Bourbon Red			Zip Code	7050	Ī	-	tizen of What C	
items 23a ver must b	-une	11. Marital Status	12. Was Decedent Ever in U.S		cedent of Hi	ispanic Origin? (Sp	pecify Yes or No-		14. Race - Am	erican Indian,
"netural", or items 23a or 28a-f sho idicel Exdrilner must be notified at	<u>م</u>	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		pecily Cuba s 2 🔀 No	n, Mexican, Puerti Specify:	o Rican, etc.)		Black, Whi Specify: Wh	ite, etc.
7 7-1	Completed	15. Decedent's Ed (Specify only highest gra		16a. Decedent's U (Give kind of life, DO NOT	work done d	ation during most of wor	rking	16b. K	ind of Business	s/Industry
a 65 €		Elementary/Secondary (0-12)	College (1-4 or 5+)			irector		Y	MCA	
of Health and Mental Hygians If Itam 27 Is merked other th in other treumatic event, the	To Be	17. Father's Name (First, Middle, Last) Thomas P. Gorma	n			18. Mother's Nar Mary	ne (First, Middle, Ann Kee:		Sumame)	
ealth and m 27 Is m		19FHOMPSOMme/Relationship (Ty Thomas M. Young		19b. Mailing Addr 16 Bourk	ess (Street a	and Number or Ru d Drive,	ral Route Numbe Mechan	r, City or icsb	Town, State, Z urg, Pe	^(ip Code) 17050 ennsylvania
Department of H Important: If Ita any Injury or oth		20a. Method of Disposition  1 \times \text{N}\text{Purial} 2 □ Cremation \text{3\text{V}\text{X}}  4 □ Donation 5 □ Other (Specify	Removal from State	lace of Disposition (f emetery, crematory of Ce of Heav		met <b>e</b> ry 1	Date 2/21/12		ocation - City o hanics	
Import any Inj once.	148 S. Church Street, Wayne									17268
ysician/ Medical xaminer	<u>H_</u>	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a	ence of):	ode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 2 weeks
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	af Hear	Tdis	seas-l				5/years
sician and a burlal-trar	<u>a</u>	that initiated events resulting in death) Last	C. Due to (or as a consequ	ence of):						
ng phy as the	Medi	IF FEMALE:	u					-		
the attendii chad for use	Completed by Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	I death 3 Ectop		ey .			23d. Date of de Month	elivery Day Year
n signed by uld ba deta	ed by P	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlyin	ng cause giv	ven in Part I.		obacco u Yes 2	_	o the cause of death?
a has baa aga 2 shoi	omplet		. 11		-	<del></del>	24a. Was autor perfo	DSV	prior to	utopsy findings available completion of cause of
rtifical ctor, p	Bec	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che		2 🖾 N	o <u>l</u> 1 ⊔ Y€	es 2 No
his ce al dira	입	1 ☐ Yes 2 ☑ No	tospital:		DOA Othe	er: 4 🗆 Nursing H	lome 5 Resid	dence 6	Other (Spe	cify)
eath. or: Aftar t tha funar	Certificate:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)	28b. Time of injury	28c. Injury work 1 🗆	/ at ? Yes 2 □ No	28d. Describe h	now injur	y occurred	
s aftar deal al Director: ed in by the	al Cert	4 Homicide determined	building, etc. (Specify)				City or Tox	vn, State,	)	ural Route Number,
5 2 = 1	Medical	(Check 2 ☐ Medical Examir	ician: To the best of my knowle ner: On the basis of examination e Practitioner: To the best of m	and/or investigation,	in my opinio	on, death occurred	at the time, date a	and place	, and due to the	cause(s) and manner state
n 24 hours ie Funaral olately fillec		29b. Signature and title of certifier	34		29c. License			29d. Da	te signed (Mon	th, Day, Year)
within 24 hours aftar death.  To the Funaral Director: Aftar this certificata has baan signed by the attending physician and complately filled in by tha funaral diractor, paga 2 should ba detachad for usa as tha burlal-transit	J					•		1200	einn Inc	2:- 17 771
within 24 hour  To the Funar, complately fill		30. Name and address of person who co	ompleted cause of death (It-	23a) (Time Di-4)	RES.	-000		uu	MIK	r 17,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ Anita A. Blank 2012 December 26, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore St. Martin's Home Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours (Month, Day, Year) 212-09-9875 Director 1 M 2 XF 97 April 9,1915 Maryland 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours efter death with the Meryland ment of Health end Mental Hygiene. sant: If item 27 is marked other than "natural", or Items 23a or 28a-f sho 10c. City, Town or Location Director an "natural", or Items 23a or 28a-f a Medical Examiner must be notified 1 Yes 2 No Baltimore Catonsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 601 Maiden Choice Lane 21228 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Ith end Mental Hygiene. 27 is marked other than r traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Dentistry Dental Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Homer Amide LaVoie Antoinette Regina Gignac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ursula McCormick/ Daughter 6221 Ironwood Way Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Depertment of
Important: If it
eny injury or o Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/7/2013 New Cathedral Cem. Baltimore, MD ature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc 4107 Wilkens Avenue Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final disease or condition Physician/ resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): anding physician and use es the burlel-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day signed by the at d be deteched f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificete hes b director, pege 2 s perform 1 Yes 2 k No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔼 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death. e Funeral Director: Af bletely filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 121649 hrkara December 28, 2012

Registrar

State

3455

Wilkers Ave. Baltimore MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MBANDAM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:00P M Physician/ Month Brockington Reember 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Nursing and Rehabilitation  $\alpha$ If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min. (Month, Day, Year) 30 5065 Director 1 🗆 M 2 🗗 F MD tin 30 1 and 2 should be filed within 72 hours efter death with the Maryland of Health end Mentel Hygiene. I fitem 27 is marked other then "naturel", or Items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Boutimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 21218 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 □ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4 or 5+) Home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Pege 1 and 2 should be Depertment of Health end Meni Importent: If Item 27 is marke any injury or other traumatic t Warrina Wise Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2523 Riggs Kismith ravers Bouto. MD 21216 - aaughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation* 3 Removal from State cemetery, crematory or other Cemetery 4 ☐ Donation, 5 ☐ Other (Specify) -5-2013 21. Signature of 6 eral Service License 22. Name and Address of Facility Garyp. Murch FH 270 Fredhilton Pass Ralto mo 21229 23a. Part 7. Into the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OLON disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to (or as a consequence of): for use es the burial-transi To the Hospital or Attending Physician: The lew requires that the death certificate be execut within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? É Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Certificate: 27. Mann eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Natural Accident М Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32.

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Hester L. Bryant December 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death BAltimere Washington Medical

5. Social Security Number 6 dex 17. Age (In un G KN Anne BurNie Center 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 498-24-4387 1 X M 2 □ F 02/12/1928 84 Arkansas Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 United States 201 Oak Lane, NW 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White "natural", Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mea gnote. Elementary/Secondary (0-12) College (1-4 or 5+) Classified Employee Department of Defense Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bruce C. Bryant Georgia F. Noland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Bray/ daughter 2333 Knobcone Ave, Anderson, California 96007 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Bµrial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 Other (Specify) Crownsville MD Vets 01/07/2013 Crownsville, Maryland 21. Signatur of Floor ral Survey. Licentee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy, SE, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cerebral UASCUMA disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 You

9 Unknown Month Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn After this certificate Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other 2 No 1 Tes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 1 Natural 28b. Time of Certificate: 28d. Describe how injury occurred injury work? 5 Pending 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours a Medical Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

Registrar
DHMH 17 Rev 06-2011

State

BAltimore: WAShington Medical Center

d cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	State of Maryland / Department State	artment of Health and N tificate of Death	20	12 42964
			Registrar  1. Decedent's Name (First, Middle, Last)	incate of Death	Reg. No C U	3. Time of Death
	siciar edica		Andrew W. Byers		DECEMBER 22	Year 202 8:55 4 M
	mine		4a. Facility Name (if not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore	4c. County o	of Death
Fune Direc			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 464-26-3275 1 🖾 N 2 🗆 F	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
		١	464-26-3275		May 23, 1925	Indiana
yland f sho	eo ar	ctor	10a. State 10b. County 10c. City, Town or Lor		•	10d. Inside City Limits
r 28a	nour	Dire	MD Baltimore Dund	alk 10f. Zip Code	10g. Citizen of Wi	1 Yes 2 No
with th	eq 1sr	Funeral Director	103 Center Place #202	21222	US	<i>'</i>
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show win intents.	xaminer m	<u>\</u>	1 ☐ Never Married 2 ☐ Married	Mas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto □ Yes 2∏ No Specify:		- American Indian, , White, etc. white
Baltimore, Maryland 21215-0036  sernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural".	e Medical E	Completed	15. Decedent's Education   16a. Decedent's County only highest grade completed   16a. Decedency (Give I)   16a. Decedenc	dent's Usual Occupation kind of work done during most of work O NOT use retired)	ing 16b. Kind of Bus	siness/Industry unk
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Mary 12 should alth and N	r trauma			ng Address (Street and Number or Rura 8 Lankford Hgwy B		
more, Page 1 and Tent of Hea	iry or otne		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Ottrer (Specify)	sition (Name of natory or other place)	Date 20c. Location - 0	City or Town, State
Balti permit. Departin Importa	once.			Name and Address of Facility tate Anatomy Board		ore Street
te be executed  Examinimized the hursil-transit	ical ner	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		emyopathy	Approximate Interval Between Onset and Death  2 WCLKS  3 WELLS  > 10 YEAN
5x 687 ath certifica attending pl	200	₩	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   4   Pregnant at time of death 5   9   Unknown	Ectopic pregnancy Other (specify)	23d. Date Mont	of delivery th Day Year
ords, P.O. Be requires that the dea been signed by the a		ব	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contrib	oute to the cause of death?
Division of Vital Records, tal or Attending Physician: The law requires after death.  In July 1997, the this certificate has been signed in by the fineral director pane? should the clin by the fineral director pane? should the clin by the fineral director pane? should the		Completed			autopsy pr performed? / de	ere autopsy findings available ior to completion of cause of sath?
Vital Rec hysician: The laven sertificate has director, page 2	'ing		25. Was case referred to medical examiner?	26. Place of Death (Check	<del></del>	
of Vi Physi Physi rthis c		유	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ patient 2 ☐ ER/Outpatier 27. Manner of Death 28a. Date of injury 28b, Time of		ome 5 Residence 6 Other 28d. Describe how injury occurred	
sion of the sion of death.		icate	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation	work?  M 1 🗆 Yes 2 🗆 No	200. Describe now injury occurred	•
JIVISION I or Attend after death Director: A	6	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
the Hospital or thin 24 hours afte the Funeral Dir		Medical (	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invest	tigation, in my oninion, death occurred a	t the time, date and place, and due t	to the cause(s) and manner stated.
To the P within 24 To the P			only one) 3 — Certifying Nurse Practitioner: To the best of my knowledge, 29b. Signature and title of certifier	29c. License number	ace, and due to the cause(s) and ma 29d. Date signed	(Month, Day, Year)
			Ramilenucaemi	D729	69 December	, 22, 2012
			only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 29b. Signature and title of certifier    Committee   C	Print) UNIV PKWY	, BALTIMORI	E, MD 21218
	State istra	-	31. Date filed (Month, Day, Year)  JAN 0 7 2013	K		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 5,  $201^{\circ}2$ 9:00 AM M Samuel W. Bayer Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 18723 Preston Road Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Months Days (Month, Day, Year) Director 213-24-9384 84 May 6, 1928 Maryland 28a-f show 10c. City, Town or Location 10a. State 10d Inside City Limits Examiner must be notified at Director 1 Yes 2X No MD Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 USA 18723 Preston Road 12. Was Decedent Ever in U.S. Armed Forces?
1 □ X Yes 2 □ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Hygiene. other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify white 151-54 Completed 3 X Widowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Daniel George Bayer Rachel Elizabeth Garber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Bayer/niece 19112 Bonnie Briar Lane Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Euneral Sovice License (1997)  $^{22}\,^{\text{Name and Address of Facility}}_{\text{State}}$  Board 655 W. Baltimore Street Wade, Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last y physician and Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificately filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2**X** No 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred ✓ Natural 5 Pending ☐ Accident☐ Suicide Investigation 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number DC6112-66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hoger & Ir un 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #25, per me, g936 2-2-13 sm
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 6 lary OYIE AN Medical 4a. Facility Name (if not institution, give Examiner 4b. City, Town, or Location of Death 4c. County of Death Medica Balt Y MORE If Under 1 Year Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country)111 K **Funeral** Oct 24, 1950 1 □ M 2 🔀 F 62 **Director** 218-58-5673 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21202 USA Funeral 111 Park Ave 12. Was Decedent Ever in U.S. Armed Forces?unk 1 ☐ Yes 2 ☐ No 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 black If Yes, Give Year or Dates. 1 ☐ Yes 2 K No Specify: Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry unk(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Thompson - friend 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State cemetery, crematory or other place) 4 □ Donation 5 X Other (Specify) in state Signature of Fundal Service 12cg 22. Name and Address of Facility State Anatomy Board Jonald , Wade, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Envoician/ disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of igned by the attending physician and be detached for use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Failer 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of ocaine 24a. Was an Director: After this certificate has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes - <del>2 X Ne</del> Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Pranticeen To the best of my knowledge death consend at the time

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

> State Registrar

29b. Signature and title of certifie

30. Name and address of perso

Baydarian

JAN O

Michael

Date filed (Month)

Priot)

29c. License numbe

Jec 30,2012

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ho completed cause of death (Item 23a) (Type

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1 Z BURKETT 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore SAMARITAN BALTIMORE HOSP ITM If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Hours 87 Director 214-38-5281 1 🗆 M 2 🖫 Feb 10, 1925 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ₺ Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21206 5706 Denwood Ave. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Completed by Maryland 21215-0036 Specify: black 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) private homes domestic unk unk Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5706 Denwood Ave; Balto, MD 21206 19a. Informant's Name/Relationship (Type, Print) Rosalind Jones - caregiver Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State cemetery, crematory or other place) Signature of Fundal Service Licens (Nonald Se 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TEAC Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à PNEUMON: A ASPIRATION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an STROKE ISCHEMIC s certificate has b director, page 2 s perform ARTHLY DISEVASE WRONARY 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 12 RES 000 20 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar LORITANN

31. Date filed (Month, Day, Year)

5601

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene								
	T — State Registrar			Cer	Certificate of Death		Reg. No. 20   2 4 2 9 6 8			
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day			Day Year	3. Time of Death		
	Medic		Pamelia W. Brooks				November		5:00 PM M	
	Examin	er	4a. Facility Name (if not institution, give street and number	)	4b. City, Town, or 1			4c. County of Deat		
***	Euperal	Chesapeake Woods  Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda				Cambridge Do  If Under 1 Year   If Under 24 Hrs.   8, Date of Birth			hplace (State or Foreign	
	Director		223-12-8733 1□M2⊠F	Vm	Months Days	Hours Min.	(Month, Day, Yo	ear) Cor	untry)	
	, A		Usual Residence of Decedent	92			Nov 1, 1	920 Virg	ginia	
	rylenc	To Be Completed by F	10a. State 10b. County	10c. City, Town or Loc					10d. Inside City Limits 1 ☐ Yes 2 🙀 No	
	r 28a		MD Dorchester  10e. Street and Number	Cambr	idge 10f. Zip Code		1 10	g. Citizen of What Co		
	ter deeth with th , or items 23e o miner must be		1300 Hambrooks Blvd			613	10	USA	unity:	
			11. Marital Status 12. Was Deceder		Vas Decedent of His	spanic Origin? (Spec	cify Yes or No-	14. Race - Ame	rican Indian,	
ထ္ထ			1 ☐ Never Married 2 ☐ Married Armed Force 1 ☑ Yes 2	□ No	Yes, specify Cuban		Rican, etc.)	Black, White		
8	urs el		3 ★ Widowed 4 Divorced If Yes, Give Year or Dates. 143-46			Specify:		Specify: white		
<u> </u>	72 ho		15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of workin life. DO NOT use retired)			ng 10	16b. Kind of Business/Industry			
2	ithin ene.		Elementary/Secondary (0-12) College (1-4 of	or 5+)	maker			own home		
ק ס	permit. Page 1 and 2 should be filed within 72 hours effer deeth with the Maryland Department of Heeth and Menell Hygiene. Department of Heeth and Menell Hygiene.  Department if them 27 is merked other than "neturel", or items 23e or 28e-f show eny injury or other traumetic event, the Mackel Examiner must be notified at once.		17. Father's Name (First, Middle, Last)	Home	maker	18. Mother's Name	(First, Middle, Ma			
<u>a</u>			William Semple Weaver			Ida Walt	on			
ary			19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					Code)		
Σ			John Brooks/son		Oak Stre	et Cambri	dge, MD	21613		
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place		ate 20	c. Location - City or	Town, State	
Ħ.			4 ☑ Donation 5 ☐ Other (Specify)							
Ba	Depermiting the permit	l a	21. Signator of porce Source Licensee P1	rector , ISt	Name and Address ate Anato ltimore,	my Board	655 W. E	altimore	Street	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate							
-	nysician		shosk or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentialfy list conditions,						Onset and Death	
	Medical examiner								3. 0	
		Examiner								
			if any, leading to immediate  Lause. Enter Uniderlying  Cause (Disease or injury				79			
		Exa	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				· · · · · · · · · · · · · · · · · · ·			
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276	ficete g phy es the	Physician/Me	_ v							
<u>چ</u>	ocerti endin r use		IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Bird		eath 3 Dectopic pregnancy			23d. Date of de	livery	
Box 687	et the ett ed by the ett deteched fo			it at time of death 5				Month Day Year		
9. O.			Part II. Other significant conditions contributing to deat	h but net resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?	
S,	ires ti sign id ba	q p	Cerebrounscular AC	cident (	)Strope	2,2010	1 🗆 Yes	2 XXX 3 □ P	robably 4 🗆 Unknown	
ord	v requ	olete	Emphesem A	,	1		24a. Was an		topsy findings available	
3ec	he iev rte hes oega 2	Completed by	En price di la constanti di la				autopsy performe 1  Yes 2		completion of cause of	
a	len: T rtifice ctor, p	Be C	25. Was case referred to medical 26. Place of Death (Check only one)							
Division of Vital Records,	hyaic his ce si dire	မ	examiner? 1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Wursing Home 5   Residence 6   Other (Specify)							
	To the Hospital or Attending Physicien: The lew requires that the deeth certificate be executed within 24 hours after deeth.  Within 24 hours after deeth.  To the Funarial Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be deteched for use as the burial-trenst	Medical Certificate:	TEMATURA SELFEROING	njury 28b. Time of Day, Year) injury	28b. Time of 28c. Injury at 28d. Describe how injury occ work?			injury occurred		
			2	M 1 ☐ Yes 2 ☐ No  ce of Injury - At home, farm, street, factory, office 28			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
				building, etc. (Specify)						
			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	vithir comp		29b. Signature and 1tle of certifier	/ nicosa of my knowledge,	29c. License			d. Date signed (Month		
			► //ous a //am 1.0. H44615 12/21/12							
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lois A Warre D.O. 100 Brambk 5+ Cambridge M)							
	Star Registra			strar's Signature	ares				0	
			WILL A LEGIO CON	- 1- 17						

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AMEND TTEM#29d perDVR, G935, 177/2013, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 4:12pm 31 December Aaron Lee Brewton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Reisterstown Brampton Court If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** 1 ★ M 2 □ F July 29 Months Days Hours Ĩ962 NC **Director** 50 227-06-1188 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits notified at 10c. City. Town or Location Director 1XXYes 2 No Chesterfield VA Petersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be 1 Funeral United States 23808 20208 Stonewood Manor Drive death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed Black Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry oe filed wit. ◆al Hygiene. ✓ar than "r Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transmitted. Food Service Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Greta Jones Paul A. Brewton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brampton Ct. Reisterstown, MD 21136 Kim David Brewton (brother) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 Donation 5 Other (Specify) 1-05-2013 Reisterstown, MD All Saints Cemetery ELINE FUNERAL HOME Signature if Funera ervice Licensee 22. Name and Address of Facility MD 21136 J.Wayne Osterling 11824 Reisterstown Rd. Reisterstown, 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer una disease or condition Medical resulting in death) Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transif Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical death certificate be P.O. Box 68760 as IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for □ Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Yunknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No page 2 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 🗆 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specific 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 X Natural 5 Pending 2 No Accident Investigation completed filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 29b. Signatu nd title of certifier 29d. Date signed (Month, Day, Year

State Registrar thatb

30. Name and address of person who completed cause of death

(Item 23a) (Type, Print)

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CT. Luthenvill

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December Pauline 2012 L. Ba11 7:50 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) 578-44-5148 Director 1 🗆 M 2 🔀 F Yrs 86 January 24, 1926 Washington, D.C. ba filed within 72 incursion fema 23e or 28e-f anow sked other than "netural", or Itema 23e or 28e-f anowastic event, the Medical Examiner must be notified at Usual Residence of Deceden 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery 1 ☐ Yes 2 🕅 No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9212 Adelaide Drive 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 ☐ Yes 2 🕅 No If Yes, Give Black White etc. 1 Never Married 2 Married <u>≨</u> Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 □ Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Montgomery County Elementary/Secondary (0-12) College (1-4 or 5+) Registrar Schools of Haalth and Mental Hygia of Haalth and Mental Hygia If Item 27 is merked other ir other treumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Albert Ray Lucas Almedia Shumato 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Ball Boswell /Daughter 4121 Sir Walter Road, Olney, Maryland 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. permit. Page 1.
Department of I importent: If its eny injury or ot once. 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State January 5, 4 Donation 5 Other (Specify) 2013 Bethesda, Maryland Inc. 21. Signature of Fundal Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Enysician, Onset and Death Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires the control of the detail of the function of the func Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical **Division of Vital** 8 26. Place of Death (Check only one) P Other: 4 \( \text{\text{Nursing Home}} \) 5 \( \text{\text{Residence}} \) 6 \( \text{\text{Other}} \) Other (Specify) 1 ☐ Yes 2 🖾 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D71517 December 31, 2012

Registrar

State

OF SO AM

Daving

8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.Ď.

32. Registrar's Signature

Natalia Vasquez Martinez,

31. Date filed (Month, Day, Year)

JAN 0 7 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DECEMBER 23, Year 2012 Steven C. Clark 3:25 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SAINT JOSE NSON MEDICALCENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 217-48-5628 1 XM 2 □ F 58 Usual Residence of Decedent 10/17/1954 Maryland or then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Catonsville 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Carroll Road 21228 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White Completed 3 - Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Carpenter Const. permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 Is marked othe any Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Stanley T. Clark, Sr. Beverly J. Bilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Brother 915 Fairview Ave., Gettysburg, Pa 17325 Stanley T. Clark, Jr. Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ■ Burial 2 □ Cremation 3 □ Removal from State 12/27/2012 Lakeview mem. Pk. Skyesville, Maryland Qonation 5 Other (Specify) . Sign ure of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death SPIRATORY Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit NEUMONIA that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 OCARDITIS IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MENINGITIS 1 Yes 2 No 3 Probably 4 Unknown INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ULMONARY EDEMA performed?
☐ Yes 2 🕱 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 🕅 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 1 Natural
2 Accident
3 Suicid 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and place, and place and place and place. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIN THICUM OSLER DRIVE TOWSON MARYLAND 21204 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 20, 2012 17:44 Charles W. Covington Jr.  $P_M$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2917 Eastern Blvd; Apt 13 Middle River Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Month Director 579-22-3172 1 🛚 M 2 🗆 F 87 Aug 3, 1925 Washington DC or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Middle River 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2917 Eastern Blvd #13 21220 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1X Yes 2 No WWII

If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) O supervisor gas company Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Love/friend 2917 Eastern Blvd #13 Middle River, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Signature Funeral Service Licensee Ronald S W 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cardiovase Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the and ld be detached for Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown peen a 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 10 2 🗌 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

npleted cause of death (Item 23a) (Type, Print)

Registrar's Signature

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Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DOD 12/24/2012 TOD 1336 matte T cordáry DOB 7/24/1924 Division of Vital Becords PO Box 68760

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			State Registrar			Cer	tificate of	Death			Reg. No		1 6	460	10
	Physicia	ın/	1. Decedent's Name (First, Middle,						2. Date of De Month	Da		Year	3. Time of Dea	ath M	
Medical Mattie Corddry  Examiner 4a. Facility Name (if not institution, give street and number)							4b. City, Town, o	or Location of	f Death	12	24		f Donth	1236	IVI
_	Examin	e	Atlantic Gener				Berli		Death		4c. County of Death  Worcester			r	
	Funeral Director		229-20-5739	6. Sex	7. Age (In yrs. 88	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir July 2	th y, Year)	924	9. Birthplace (State or Foreign Country) Virginia		reig <i>n</i>
	nd <b>how</b> at	'n	Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Loc	eation						10	d. Inside City Lir	mits
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213-0036	permit. Page 1 and 2 should be fled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	Narital Status     Never Married 2 ☐ Marri     Widowed 4 ☐ Divorced	Armed For	2 <b>X</b> No e	"	<ol> <li>13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Richt 1 ☐ Yes 2 ☑ No Specify:</li> </ol>					ecify Yes or No- Rican, etc.) 14. Race Black Specify:			
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yland	uld be filed Mental H narked ot natic even	To B	17. Father's Name (First, Middle, Last)  Samuel Tinsley  18. Mother's Name (First, Middle, Maiden Surname, Maude Booker												
, Mar	and 2 shou lealth and em 27 is n ther traum	1	19a. Informant's Name/Relationship (Type, Print)  Barbara Trader – daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or 4718 Nassawongo Rd; Snow Hill;												
baltimore	L. Page 1 s trment of H tant: If ite jury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (St	pecify)			natory or other pla			Date		ocation - 0	•	n, State	
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			30. Name and address of person w Christopher		e of death (Item <b>00E Car</b>	n 23a) (Type, Pi roll S	_{int)} t. Salis	bury,M	D 2	1801					
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	Registra	ir	JAN 0 7 20	13 Sens	w p.	yan									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2, 2012 4:00 PM M David L. Cornwell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 101 Gardner Drive Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Hours Director 307-46**-**8734 1 ▼ M 2 □ F 67 June 14, 1945 Indiana Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel 1 🗆 Yes 2 😾 No Annapolis 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 101 Gardner Drive 21403 USA within 72 hours after death 12. Was Decedent Ever in U.S. Arghed Forces?

1 ⚠ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced **'**66-68 Specify: white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) 12 US Congressman US Governmen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lowell Eugene Cornwell any injury or other traumatic Dolores Elaine Klaas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Jane Cornwell/spouse 101 Gardner Drive Annapolis, MD 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 <u>Baltimore,</u> Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) kidney cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed and use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perforn hours after death. Ineral Director; After this certificate 1 Yes 2 No __ Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) <u>P</u> Other: 1 🗌 Yes 2 No 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No Vatural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours To the Funeral I Medical 29a. Certifier Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DS2830

Medical Pancing

#20,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ :45 A M Dec 2012 NORBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 022-24-1645 80 1 M 2 □ F Director 6-27-1932 Massachusetts 27 is marked other than "natural", or items 23e or 28a-f show treumatic event, the Medical Examinar must be notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Anne Arundel Severn 1 🗆 Yes 2 No 10f, Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 1877 Montreal Road USA Severn permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or Items 2 ery Injury or other treumatic event, the Medical Examinations. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Army Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Drumm Ferguson Maude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1877 Montreal Road Severn MD 21144 Mrs Lori E Bivins/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Arlington National 4 Donation 5 Other (Specify) Arlington, Virginia 21. Signature of Funeral Ser 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy, SE, Glen Burnie, MD 21061 23a. Part 1. Infer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physic and ongestive Medical resulting in death) Due to ( as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit or Attending Physician: The law requires that the death certificate be executed after death. Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performe 1 Yes 2 No performed∠ 1 ☐ Yes 2 🛣 No Division of Vital 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hoapital or Attending Phyalo within 24 hours after death.

To the Funeral Director: After this ce completely filled in by the funeral dire 2 No 1 Inpatient 2 ER/Outpatient 3 DOA |၉ 1 🗌 Yes 28c. Injury at work? 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

Bennett

31. Date filed (Month, Day, Year)

JAN O

MD

Annapolis

21401

Pkw

30. Name and Iddress of person who completed cause of death (Item 23a) (Type, Print)

Medical

Box 68760 P.O. Hospital or Attending Physician: The law requires in 24 hours after death.
Funeral Director: After this certificate hes been sign ately filled in by the funeral director, page 2 should be Records, of Vital Division To the Hosp within 24 hou To the Funer complately fil

Baltimore, Maryland 21215-0036

29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or in the basis of examination and/or in the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 2 Medical Examiner: To the best of my knowledge, de 3 Medical Examiner: To the best of my knowledge, de 3 Medical Examiner: To the best of my knowledge, de 3 Medical Examiner: To the best of my knowledge, de 3 Medical Examiner: To the best of my knowledge, de 3 Medical Examiner: To the best of my knowledge, de 4 Medical Examiner: To the best of my knowledge, de 4 Medical Examiner: To the best of my knowledge, de 5 Medical Examiner: To the best of my knowledge, de 5 Medical Examiner: To the best of my knowledge and the first of the best of my knowledge.	nvestigation, in my opinion, death occurred a	t the time, date and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
+ tehis Clark, MB	D0031315	12-23-2012
30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	
Fabio Olarte 400 West 7th Stree	t Frederick,MD 2170	1 .
31. Date filed (Month, Day, Year) JAN 0 7 2013  22. Registrar's Signature	all	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 15, 2012 1:41 Rodney Philip DeAngelis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 3734 Echodale Avenue If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min Director 215-44-0499 1 X M 2 □ F Oct 14, 1945 Maryland 67 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland at Director notified 1

Yes 2 □ No 28a-f Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ms 23a or must be r Funeral 3734 Echodale Avenue 21206 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, "natural", or ite Armed Forces Black, White, etc. 1 Never Married 2 Married þ 2 X No 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene.
Item 27 is marked other than "natural". or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Completed th and Mental Hygiene. 27 is marked other than "natun traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 family therapist psychology Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Connie DeAngelis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald Steinberg/friend 9101 Field Road Pikesville, MD 21208 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in State Signature of Feneral Service Licenses Ronal d S Na 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Name and Address of Facility rector) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, a heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Coronay arter Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** adetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Physician/Medical to the Hospital or Attending Physician: The law requires that the death certificate between the Funeral Director. After this certificate has been completely filled in her than the funeral princetor. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
4 ☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Deliuot 1 Yes 2 No 3 Probably 4 Unknown om is read past 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performer 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Mark Lamos M 12-19-2012 034521 MD Lames (M) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month vene 12:12 P M 201Z Medical ion, give street and number) Many land Shock Traun with Greene Street 4a. Facility Name (if pot institution
UNIVEYSHY OF
CENTEY 22 Son Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Aug Year) 1923 Days 214-20-3320 Hours Maryland Director 89 1 M 2 X F 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other then "nature!", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A **Baltimore** 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 5111 Eugene Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 XNO
If Yes, Give
Year or Dates. Black, White, etc <u>۾</u> 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life, DO NOT use retired)
Homemaker during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Benedict Aleseunas Julia Zeladon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8316 Montpelier Drive Laurel MD 20708 Kenneth Elane / son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Most Holy Redeemer Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State 1/7/13 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/License 22 Name and Address of Facility Leonard J. Ruck, 5305 Harford Road Inc. Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 N/S Immediate Cause (Final Physician/ multiple disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospitai or Attending Physicien: The law requires thet the death certificate be executed To the Hospital or Attending Physicien: The law required to the attending physicien and To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funerel director, page 2 should be deteched for use as the burlel-tren resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 🔲 Ectopic pregnancy 5 Other (specify) Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 1 Yes 2 No 25. Was case referred to medical examiner?
1 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 ☐ Natural 2 ☑ Accident 5 Pending work? 1 ☐ Yes 2 ☑ No 29/2012 tall Investigation 2355 PM 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6316 Mon Pelver determined Drive -aurei Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The definition of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Definition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene Street, Baltimore, MD 22 1 ennusor 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 201^{Yea} Rowland Ε. Ekunwe December 0006 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Springs Holy Cross Hospital Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 585-08-4023 Director 1 🗓 M 2 🗍 F 63 Oct. 10, 1949 Nigeria er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sent: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director TXFort Bend Sugar Land 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14314 Ayers Rock Road 77498 IISA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 Black 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Divorced 4 Divorced Completed ar or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Production Manager Oil, Gas Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14314 Ayers Rock Road, Sugar Land, TX Lanikki Ekunwe - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Department of Importent: If eny injury or once. 12-19-12 Houston Memorial Gdns Houston, Texas 4 Donation 5 Other (Specify) 22. Name and Address of Facility Metropolitan Funeral Service 21. Signature of Funeral Service Licensee 5517 Vine Street, Alexandria, VA 2 a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ESRD disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been slaned by the attending physician and attending physician and I for use as the burlal-transII Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by **Hypertension** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Diabetes Mellitus autopsy 1 ☐ Yes 2 ☒ No To the Funerel Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Yes 2 🗓 No |요 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 1 🖾 Natural 5 Pending injury 2 Accident
3 Suicide
4 Hornicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place; and due to the cause(s) and manner as stated. wired at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10069829 who completed cause of death (Item 23a) (Type, Print) Park drive, montgomery Village AQVI 18566 Office State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 42980 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day **04:45** a ^M Wallace Homer Francis, Jr. 2012 Medical Dec 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Director 215-28-4270 1 XM 2 □ F 80 Dec. 19,1932 Maryland parmit. Pege 1 and 2 should be fliad within 72 hours after death with tha Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is merked other then "neturel", or itame 23e or 28a-f show eny Injury or other treumetic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 2110 Parksley Avenue **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 X Married Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White 3 Widowed 4 Divorced '50-'53 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) US Postal Service Postal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Catherine Doerr Wallace Homer Francis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2110 Parksley Avenue Baltimore, Maryland 21229 Joan V. Francis - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 12/29/2012 Brooklyn Park, MD Cedar Hill Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Heather Simons 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RESPIRATORY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ACUTE ON CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). igned by tha ettending physician end be datached for use es the buriai-transif DECOMPENSIATED CONGESTIVE Hospital or Attending Physicien: Tha lew requiras that the deeth certificete ba execute that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an cartificate has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No burs efter death. arei Diractor: After this cartifics filled in by the funaral director, I 8 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 1(KC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To tha Hosp within 24 hou To tha Funal compietaly fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) as MD D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD ABBAS

Registrar DHMH 17 Rev 06-2011

State

EDAR

ANE

BLUMBIA

6336

MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 42981 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ December 13, 2012 12:30 P M Frank John Falcone Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 108 Washington Street Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 219-36-2308 Director 1 🗓 M 2 🗆 F Dec 3, 1939 73 Washington DC Usual Residence of Decede show at 10c. City, Town or Location 10d. Inside City Limits Director Department of Health and Mental Hygiene. Important if items 23a or 28a-f'sl important: if items 27 is marked other than "natural", or items 23a or 28a-f'sl any injury or other traumatic event, the Medical Examiner must be notified a one. 1 Yes 2 No <u>Baltimore</u> MD Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 108 Washington Street 21093 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) manufacturing rep Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank James Falcone Helen Lorraine Yocum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita J. Falcone/spouse 108 Washington Street Timonium, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) ²² State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Baltimore, MD 21201 Approximate Interval Between Onset and Death Physician/ CONGESTIVE disease or condition Medical resulting in death) Examiner CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the nding IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten in the past 12 months? Day Year Pregnant at time of death
Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINSON'S DICHAGE Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 50047625 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARD A. N'MAILCH, M.N. 7600 OS LER DRIVE, SVIFE 311. A. O'MAI State Registrar

			Please amend #9 1 _ ^{For}	State of Mar					ure A G935 and M	II Copie 1/31/2 Iental Hy	s <b>Are</b> 2013 ⁄giene	Legible	<b>.</b>	
			Registrar  1. Decedent's Name (First, Middle, Las	st)	Ce	ertificat	e of E	Death		2. Date of De	Reg. No	201	2 4 2 3. Time	982
	Physicia Medi		Zelma E. Frankl			D					Month Day Year			AM M
marco	Examir	ier	4a. Facility Name (if not institution, give Joseph Richey H		4b. City, Town, or Location of Dea Baltimore					th 4c. County of Death				
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (/	n yrs. last birthday	) If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bii (Month, Da		9. B	irthplace (State	or Foreign
			Usual Residence of Decedent  10a, State  10b. County	□ M 2 🖾 F	62 Yrs.					June 3	0, 19	950 <b>Ma</b>	ryland	
	Marylan 8a-feh	recto	MD MD	['	Oc. City, Town or I Baltim								10d. Inside	City Limits es 2 □ No
	with the 7 23a or 2	Funeral Director	10e. Street and Number 35 N. Fairmount	Avenue		10f. Zip		21205			10g. Cit	tizen of What C	Country?	
9	or Items	by Fun	11. Marital Status unk	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 🛣 No		. Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	- [	14. Race - Am Black, Wh		
-03	ours aft stural", sel Exa	eted	3   Widowed 4 ☐ Divorced  15. Decedent's E	If Yes, Give Year or Dates.		1 🗆 Yes							black_	
21215	vithin 72 h Ilene, ir than "ne the Media	Be Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5+)	(Giv	edent's Usua e kind of wo DO NOT use	rk done d		of workir	_{ng} unk	16b. K	ind of Busines	s/Industry	unk
/land	d be filed v Mental Hyg erked othe	To Be	17. Father's Name (First, Middle, Last)  Walter John Jo		<u> </u>	-	ınk-	18. Mothe		(First, Middle,				'unk'
, Man	id 2 shoul eith and h n 27 is me er treume		19a. Informant's Name/Belationship (7) Leonard Joseph Joseph Richey Ho	pe, Print) brother <del>SPICE</del>	19b. <b>1/9</b>	OS ^{Ad} Ch	ippei Law	Stre	PI Rural	April My 02	r, Citypy e, M	<b>Indisor</b> , 1	Trits,M	D 2124
Baltimore, Maryland 21215-0036	permit. Pege 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hyglene. Important: If Item 27 is merked other than "netural", or Items 23a or 28a-f ehow amy Injury or other treumetic event, the Medical Examiner must be notified at once.	2 18	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specin	Removal from State	20b. Place of Disp cemetery, cr			е)	D	ate	20c. Lo	ocation - City o	or Town, State	
Bai	permit Deper Impor any In		21. Signature of Funeral Service Licens	Wades Direc	tor S	altim	Anato	omy B	oard 2120			timore	Street	
F	hysician/		23a. Part 1. Enter the direase, or companies, ock, or heart failure. List only of Immedia. Cause (Final disease or condition	olications that caused the ne cause on each line.	e death. Do not er	nter the mod	e of dying	g, such as o	cardiac o	r respiratory ar	rrest,		Approxima Interval Be Onset and	etween
	Medical Examiner	resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											7	
	cuted nd transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
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Division of Vital Records, P.O. Box 68760	Attending Priysician: The law requires that the deeth certificate be executed at death of the third set this certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	FFEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1									23d. Date of d	elivery Day	Year
Js, P.O	requires that the dee been signed by the e should be detached t	ed by P	Part II. Other significant conditions of	ontributing to death but r	not resulting in the	underlying o	ause give	en in Part I					o the cause of	
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Ita	Fnysician: The right cartificate It and director, page	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:			Othe	ce of Deat		only one)			- 11	
on of \	r Attending Pny er death. rector: After this by the funeral o	cate: To	27. Manner of Death  1 X Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Ye	2 ER/Outpati 28b. Time injury		Bc. Injury work?	4 ⊔ Nu	2	ne 5 L Resident Resid		occurred	cify) (   C	pice
≥ :	al or Arte s after des I Director od in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined			reet, factory			-	28f. Location (\$ City or Tox			ural Route Num	iber;
	lo the hospital or within 24 hours afte To the Funeral Dir. completely filled in	Medical	(Check 2 L Medical Exami	ician: To the best of my ner: On the basis of exam the Practitioner: To the be	nination and/or inve	stigation, in r	ny aniniar	n death occ	curred at t	the time date a	and place	and due to the	cause(s) and m	anner stated.
	Voithi Con		29b. Signature and title of certifier	2			License		1			e signed (Mont		
			30. Name and address of person who c	ompleted cause of deal	1 (Item 23a) (Type,	Print)	13.	MA	215	7#30	<u>.</u> کد	BALTI	Nort	M
	Stat Registra	-	31. Date fi (Month, Day, Year)	2. Registrar's	Signature .	Kel								21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #27, per me 935 1-26-13 sm
State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LEENE 94RR19 5:45 PM Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death MA Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 62-55 Hours (Month, Day, Year, Director 1 M 2 1 F TRGINIA 28a-f show Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Modeal Examiner must be notified at 10a State 10b. County **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? U.S.A 2120 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. à 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed 3 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ondary (0-12) College (1-4 or 5+) TENNSTRESS æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BROWN ဂ္ဂ 19a. Informant's Name/Relationship (Type, Print) Method of Disposition 20b. Place of Disposition (Name of Acemetery, crematory or other) Depertment of H Important: If ite any Injury or ot once. Date City or Town, State 1 Burial 2 Cremation 3 Removal from State BURNIE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee REDNI 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Colon Concer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CT PATIFICATION APPROVED BY MEDICA Sequentially list conditions. Examine if any, leading to immediate Due to for as a consequence of Cause (Disease or injury eral Director: After this certificate has been signed by the attending physician end filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exectivithin 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician er resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 🗶 No 114/2012 100 PM 2 X Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5354 SINGAIN LANC#C, BALLEMONE nome Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitions. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Nilose 1650 time MD ZIZ3) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical e (if not institution Location of Death Examiner 4c. County of Death N/A If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country) MD 213-28-0878 (Month, Day, Year) 08/02/1931 Director 1 🔀 M 2 🗆 F 81 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at i and 2 should be filed within 72 hours after death with the Maryland fleatth and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 N. Broadway 21205 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. Š 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed UNK 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Lacy Graham Mozell Bacoat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Price 1027 N. Broadway Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
important: If ite
any injury or ott 1 Burial 2 Carcemation 3 Removal from State 4 Donation 5 Other (Specify) On-Site Crematory Baltimore, 22. Hame and Address of Facility OWN, 21. Signature of Funeral Service Licenses Funeral Home PA ltimo<u>re, MD 21217</u> Jr. 2140 N. Fulton Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for it in the past 12 months?
1 Yes 2 No Month Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No After this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 2 🗆 No after death Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-000 DECEMBER 30. Name and address of person who complete

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

<b>Physician</b>
/Medical
Examiner

**Funeral** 

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaniher must be rediffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

700de,

1 - State Registrar	State of Maryland		tificate of			Reg. N	20	12 429	38
1. Decedent's Name (First, Middle, Last)					N.		ay IV	Year 2012 0000	
Frances Goode  4a. Facility Name (If not institution, give si	reet and number)		4b-City, Town, o	r Location of D		cembe	c. County	aluiz	
St. Agnes Ho	earte l		2-11	more					
5. Social Security Number 6. Sex 217-62-4421	7. Age (In yrs. la M 27 F 59	st birthday) _ Yrs.	If Under 1 Year Months Days	If Under 24	Ain. (f	ate of Birth Month, Day, Yea g 12, 19	r) 953	9. Birthplace (State or Country) Maryland	Foreig
Usual Residence of Decedent  10a. State 10b. County	100 City	Town or Loca	etion					10d. Inside City	Limit
10a. State 10b. County MD	Toc. City,		imore			.,		1√∑Yes 2	
10e. Street and Number  10 N. Rock Glen R	oad		10f. Zip Code	21229		10g. C	Vhat Country? USA		
11. Marital Status unk 1  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1		/as Decedent of H Yes, specify Cub ☐Yes 2 1 No	e - American Indian, ck, White, etc. :: black					
15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give k	ent's Usual Occup tind of work done O NOT use retire	during most of	<b>UI</b> working	1k 16b.	Kind of Bu	usiness/Industry	
8 17. Father's Name (First, Middle, Last)	0		unk	18. Mother's	Name (Fire	st, Middle, Maide			unk
19a. Informant's Name/Relationship (Typ	e Print)	19b Mailing	Address /Street	and Number o	r Rural Ro	ite Number Cit	or Town	State, Zip Code)	-
William Hawkins/f			Garret					21218	
20a. Method of Disposition  1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Pi	ace of Dispos	ition (Name of atory or other plan		Date			City or Town, State	
21. Signatura Equital Signatura Licence			Name and Address State Ana Baltimore			655 W. I	Balti	more Street	
23a. Part Enter the disease, or complic shock or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Due to (or as a consequence to (or as a consequence).	Do not ente				piratory arrest,		Approximate Interval Betwo Onset and De 5 Hours	eath
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 🗌	Ectopic pregnand Other (specify) _	су		te of delivery onth Day Ye	e ar		
Part II. Other significant conditions cont	ributing to death but not resul	ting in the un	derlying cause giv	en in Part I.		23e. Did tobacc	tribute to the cause of de	ibute to the cause of death?	
HIV						1 ☐ Yes	2 □ No	3 Probably 4₹ Ur	nknow
Hepatitis	- Pilmorary	Dise	a Se			24a. Was an autopsy performed? 1 □ Yes 2 ☑	,	Were autopsy findings at prior to completion of car death? 1 □Yes 2☑No	
25. Was case referred to medical examiner?	spital:		Ott	er.		eck only one)			
1 ☐ Yes 2 ☑ No ☐ ☐ 27. Manner of Death	1 ☐ Inpatient 2 € ,E	ER/Outpatient 28b. Time of	28c. Inju	4 ∐ Nursir		5 Residence Describe how in			
1 ☑ Natural 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Year)  28e. Place of Injury - At hor	Injury ne, farm, stre	per or Rural Route Numb	ber,					
29a. Certifier 1/2 Certifying Phys	building, etc. (Specify	vledge, death			place, and		e(s) and m		
(Check only 2 Medical Examin	er: On the basis of examinat and manner stated.	iori ang/or inv	esugation, in my	opinion, death	occurred a	une ume, date a	anu piace,	and due to the cause(s)	
29b. Signature and title of certifier		MD	29c. Licen:	se number	1.8		Date signe	ed (Month, Day, Year)	17
30. Name and address of person who cor	npleted cause of death (Item	> /-	Print)	BALT	MOR			21229	
31. Date filed (Month, Day, Year)	2. Registrar's Signat	ure	4.0	)-1					
JAN 0 7 2013	Dender B.	gar	VENJE						

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown 8523 Fieldway Drive 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 ₹ M 2 □ F 243-44-2257 Director 05/11/1930 Yrs NC 82 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 end 2 should be filed within 72 hours efter death with the Maryland of Heelth and Mantal Hygiene. Item "natural", or items 23a or 28a-f sho other traumetic event, the Madcal Ex. of ref must be notified at Director Baltimore Randallstown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21230 8523 Fieldway Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Auto Steel Worker Armco Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isabella Bell Ernest Gill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kasen Michele Gill / Daughter 8523 Fieldway Dr. Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date permit. Page 1 e Depertment of I Important: If its any injury or ot once. 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State Garcison Forest VA Cenetery 01.08.2013 Owings Mills,MD Domation 5 Other (Specify) Signatur 3 Name and Address of Facilities Funeral Directors, P.A. Park Hights Ave Baltimore, MD 21215 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between lock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ er Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter underlying Examiner Due to (or as a consequence of) Cause (Disease or injury Hospital or Attending Physician: The lew requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed 2 🚺 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funerei L Medical 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

State

31. Date filed (Month, Day, Year 1AN N 7 2013

			For	State of M	1arylan	d / Depa	artmen	t of H	ealth a	and M	lental Hy	giene	,			
			State Registrar			Cer	tificate	of D	eath			Reg. No	<u>, 2 (</u>	)   2	4	2988
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7	ygien ygien her th	Be Co					N/A						N/A			
and	e filec ntal H ed ot ever	To B	17. Father's Name (First, Middle, Last)  Jimmy J. Grager								(First, Middle, Tate	Maiden	Surname	)		
Maryland	2 should be filed with h and Mental Hygien 7 is marked other to traumatic event, the		19a. Informant's Name/Relationship (Type	ne Print)		10b Mailin	a Addrana				Route Numbe	Oitu ou	Taura C	tota Zin (	la dal	
	d 2 sh alth ar 27 is rrtrau		Jimmy J. Grager			2068-	·1 Jac	kson	Rd.	, An	drews A	irfo	orce	Base	MD	20762
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Ĕ	Page ment tant: I		1 ☑ Byrai 2 ☐ Cremation 3 ☐ 4 ☐ ponation 5 ☐ Other (Specify	Hemoval from State		yer Ce				1-5	-13	Wil	lliar	nsbur	g, PA	A
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service License	e ///		22	Name and	Address	of Eacility	Fun	eral Se lexandi	rvio	ce.	22216	1	
	202.00		23a. Part 1. Enter the disease, or compl	lications that cause	d the death								VA	22310		
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	Medical		disease or condition resulting in death)	a. CONGEN  Due to (or as			GALOV	IRUS	INF	ECTI	ON			-		
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	death certificate be executed re attending physician and ed for use as the burial-transit															
220	icate g phys	ledi	d													
(687	ath certifica attending p	an/N	ZOD. Was decedent pregnant	23c. If yes, outcome 1  Live Birth			Ectopic p	roanonou				- 4	23d. Dat	e of delive	ery	
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ion	tendi death tor: A the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	00 Bl (1			М		es 2 🗆							
Division of Vital Records,	or Attence after death Director: , d in by the	Cer	4 Homicide determined	28e. Place of In building, et	jury - At nor tc. (Specify)		et, ractory,	опісе		12	28f. Location (\$ City or Tov			r or Rural	Route Nur	nber,
	Hospital	lical	29a. Certifier 1 X Certifying Physi	ician: To the best o	f my knowle	edge, death o	ccurred at	the time,	date and	place, an	d due to the ca	ause(s) a	nd mann	er as state	ed.	
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach.	Medical	(Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of e Practitioner: To the	examination he best of m	and/or invest y knowledge,	gation, in m death occu	ny opinion, rred at the	, death oce time, date	curred at e and pla	the time, date a ce, and due to t	ind place the cause	, and due (s) and m	to the cau anner as s	ise(s) and r tated.	nanner stated.
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			30. Name and addless of person who co SHANNON L. RIGLE		ueath (Item	∠3a) (Type, P			REED A, MI			ILLII	ARY	MEDI	CAL (	ENTER
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T DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland, Department of Health and Mental Hygiene For State Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1453 PM tler gvern Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner n/a If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 579-62-3973 1 🗆 M 2 💢 F 63 12/27/1948 D. C. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 🗆 Yes 2 😿 No MD Prince George Bowie 10f. Zip Code **20716** 10e. Street and Number 10g. Citizen of What Country? 3800 Enfield Chase Court, Apt. 115 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify Black 3 Wildowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "reany injury or other traumatin". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Legal Bookkepper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Irene Anderson James Elmer Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gmerice McNeil / Daughter 4009 Walney Court, Charlotte, NC 28215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 12/28/2012 Glen Burnie, Maryland 4 □ Ronation 5 □ Other (Specify) Atlantic Crematory Signatu of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to for as a consequence of Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events nding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending plant of for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Month Year ate has been signed by the a page 2 should be detached it 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erformed' 1 ☐ Yes 2 No certificate 1 X yes 2 ☐ No : After this certifica e funeral director, p 25. Was case referred to medical **Division of Vital** æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident 5 - Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur Investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

hawn Shane Hen	Ty 1- For State	State of Maryland	Department of Certificate of		d Mental Hy		. 2013	2 42990
Physician/	Registrar  1. Decedent's Name (First	, Middle,Last)	Cortinoato or	- Boutin		Reg 2. Date of Death		3. Time of Death
ledical Examine	Shawn Sha	ane Henry				Month December 3		1415 hrs
	4a. Facility Name (if not in 3809 Brooklyn Av	stitution, give street and number) venue		4b. City, Town, or Baltimore	Location of Death		4c. County of Deat	N/A
Funeral	5. Social Security Number	1 7	e (In yrs. last birthday)	If Under 1 Yea		-	(MM/DD/YYYY) 9. Bit	an
Director	213-11-60	123,001 2	36 Yrs	S. Mortins Days	s Flours Will.	05/06	/19/6 c	ountry) MD
any	Usual Residence of Deced 10a. State 10b. C		10c. City, Town or Locat	ion				10d. Inside City Limits
	MD	N/A	Baltimor	·e				1 X Yes 2 No
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r death with or items 23	11. Marital Status 1 Never Married 2	Married 12. Was Decedent Armed Forces? 1 Yes 2		as Decedent of His es, specify Cubar	panic Origin? ( Sp , Mexican, Puerto I	ecify Yes or No- Rican, etc.)	White, etc.	rican Indian, Black,
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5-0036 ed within 72 hours lygiene. other than "natus he Medical Exam		n (Specify only highest grade com (0-12) College (1-4 or 5 2 Yrs	during m	ost of working life	DO NOT use retir		Self-Emp	
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MD 212 d 2 should be lith and Ment n 27 is mark aunatic even	19a. Informant's Name/Re	enry (Sister)	19b. Mailin 2 4 2 4	g Address (Stree	et and Number or R	111 203	21244	e. Zin Corde) , MD
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Baltimore, permit. Pages l at Department of Her Important: If ite	4 Donation 5 O 21. Signature of Funeral S		Main 22.1	Name and Address	H. Brown Fulton A	n, Jr. Ave. Ba	Funeral	Home PA MD 21217
Physician	23a. Part I. Enter the dise failure. List only one	ase, or complications that caused cause on each line.	the death. Do not enter	the mode of dying,	such as cardiac or	respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final or condition resulting in d	disease a. Tubuloir	nterstitial	Nephriti	is			Death
and the	Sequentially list condition	b						
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			3a,27 per m	e g936 2.	-27-13 vt	: 	Tood Date of delive	
6876 ertificat ding phy	IF FEMALE: 23b. Was decedent pregn: past 12 months?	4 Pregnant at	2 F	etal death 3 other (Specify)	Ectopic pregna	ncy	23d, Date of delive Month	Day Year
D. Box the death c by the atten ached for us	1 Yes 2 No 9	Unknown 9 Unknown  conditions contributing to deat	h but not resulting in the	underlying cause	given in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
P.O. E res that the d signed by the detached	3				<u></u> ,	1 Yes	2 No 3 Pro	obably 4 🗹 Unknown
Division of Vital Records, lat or Attending Physician: The law requires is after death.  To Director: After this certificate has been signed in by the funeral director, page 2 should be attended.						24a. Was a autops perform	y prior to ned? death?	
Vital Recysician: The his certificate director, page		medical		26 Plac	e of Death (Check			
Physician r this certi	1 Yes 2	NO	ent 2 ER/Outpatier				Residence 6 Oth	er: Scene
n of Inding Ph		28a. Date of Inju (Month, Day,)	ury 28b. Time of Year)		ury at Work? Yes 2 ☐ No	28d. Describe n	ow injury occurred	
Division o spital or Attending sours after death. neral Director: After filled in by the fune	2 Accident 3 Suicide 6	Investigation	njury - At home, farm, stre	eet, factory, office	building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Divisior  To the Hospital or Attence within 24 hours after death  To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifier (Check only one) 2 Medi	fying Physician: To the best of m	ny knowledge, death occi amination and/or investig	urred at the time, o ation An my opinio	late and place, and n, death occurred a	due to the cause at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
Tot with com	29b Signature and title o	and manner stated		29c. Licen			29d Date signed (M	
Dane !	Colle	un	NIN	O.C	.M.E.		January 1, 201	3
i or pro	30. Name and address of Zabiullah Ali, M.	f person who completed cause of D. Assistant Medical E		Baltimore Str	eet, Baltimore.	MD 21223		
Sta		6415	ar's Signatur	wed				
Registra	m JAN	U 7 2013 Lener	~ Jo. 19"	-				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arthur Peyton Howard December 2012 12:13 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlestown Retirement Home Baltimore Catonsville 5. Social Security Number 8. Date of Birth (Month, Day, Nov 13, **Funeral** 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Director 220-12-2029 1 M 2 F 87 Maryland Usual Residence of Decedent or items 23a or 28a-f show 10b. County traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director 10d. Inside City Limits MD Baltimore Catonsville 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 717 Maiden Choice Ln; Apt 123 21228 USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: than "natural", Specify: White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation Un 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e (1-4 or 5+) unk Elementary/Secondary (0-12) College (1-4 and Mental Hygiene, is marked other tha of and 2 should be filed wired Hygie of Health and Mental Hygie fitem 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oscar Tindle Howard Arinthia Florence Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy A. Howard - wife 717 Maiden Choice Ln #123; Catonsville, MD 21228 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service License Ronald S. Wane, Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 WI rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Imm plate Cause (Final Onset and Death Physician/ CA with Medical resulting in death) Due to (o (a) a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the cause (Disease or injury that initiated events Examine Due to (or as a consequence of): burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ģ in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Day 9 Unknown been signed by the a should be detached 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an nas autopsy performed death? After this certificate 2 🗌 No Hospital or Attending Physician: 724 hours after death. Funeral Director; After this certifice 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier

Registrar

DHMH 17.Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BIVKHARCH

32. Registrar's Signature

KVISTI1

Day, Year) 7 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 99 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Jime of Death Harris Physician/ Month 30A 2012 . Medical 4a. Facility Name (if not institution, give street and number) or Location of Death Examiner 4b. City, Town, 4c. County of Death Samaritan Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** (Month, Day, Year) Min 1 🗆 M 2 Yrs. Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 4212 Dag 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Newer Married 2 Married by 1 ☐ Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No "natural", Completed 3 ■ Widowed 4 □ Divorced Specify: Year or Dates traumatic event, the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harris MI) 2/239 0 20a. Method of Disposition 20b. Place of Disposition (Name of gemetery, crematory or other place 20c. Location - City or Town, State ь Burial 2 ☐ Cremation 3 ☐ Removal from State wings Mills MM injury o 4 ☐ Donation 5 ☐ Other (Specify) 10-2012 Signature of Funeral Service Licensee 22. Name and Address of Facility Vaushn 4905 Roac or 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Paymician/ disease or condition resulting in death) p the Medical Jurs Due to (or as a consequence of): xaminer are Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (br/as a consequence of): a31 The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō 5 Other (specify) Month Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached t <u>P</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? After this certificate 2 XNO ☐ Yes 1 🗌 Yes To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to 25. Was case referred to medical Division of Vital To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yeş 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, (ear) 30 201 3 Janua 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 560 Blod de 32. Registrar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 2012 7:15 P M Physician/ December Emile Haas Victor Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Montgomery Bethesda <u>Suburban</u> Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex (Month, Day, Year) **Funeral** Days Hours Months 1 X M 2 □ F **Director** 063-07-6030 Yrs. April 28, 1917 New York 95 Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location ed other then "neturel", or Items 23e or 28a-f show event, the Medical Examiner must be notified at 10a. State within 72 hours efter death with the Maryland Director 1 Ves 2 N No Bethesda Montgomery Maryland 10q. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20817 United States 4925 Battery Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces?
1 X Yes 2 No <u>ج</u> 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes Give White 3 Widowed 4 Divorced Year or Dates. WWII Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 tel Hyglene. College (1-4 or 5+) Flementary/Secondary (0-12) Electronics Owner/President 12 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pege 1 and 2 should be filed Department of Heelth and Mentel Hy Important: If Item 27 is merked oth any Injury or other treumetic event, 2002. 17. Father's Name (First, Middle, Last) ည Martha Rosenbaum Richard Emile Haas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5815 Edson Lane, Rockville, Maryland 20852 Michelle Johnson/Granddaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place)
Montgomery January 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Bethesda, Maryland 2013 4 ☐ Donation 5 ☐ Other (Specify) Inc. Crematorium. Robert A. Tumphrey Tuneral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service/Licensee 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 shot. M01360 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): igned by the ettending physicien and be detached for use es the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the deeth certificate be 1915 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy Box Month Day in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown o 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Coronary Artery Disease, Dementia Ś Completed pege 2 should Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Congestive Heart Failure autopsy performed? Yes 2 No has 1 ☐ Yes 2 ☐ No After this certificate I 26. Place of Death (Check only one) by the funeral director, 25. Was case referred to medical or Attending Physicien: Be Vital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 2 X No မ 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 28a. Date of injury **Division of** 27 Manner of Death Certificate: (Month, Day, Year) injury X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation ☐ Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or A within 24 hours after To the Funerel Direct completely filled in b Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 1, D68160 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D. Kimberly Zuzak, 31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | | 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 John M. Inderdohnen PM M ecember :18 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Columbia Columbia Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Min. Hours Director 214-42-4766 1 🕅 M 2 🗆 F 68 1944 New York permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Yes 2 V No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1708 White Oak Drive 20910 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 salesperson plastics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John F. Inderdohnen Doris I. Schaus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jill Inderdohnen/sister 544 Church Street #206 San Francisco, CA 94114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 → Other (Specify) Funeral Struce Licent 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Signatur MD Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death STAGE Immediate Cause (Final END Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The lew requires that the deeth certificate be executed burlal-transli Due to (or as a consequence of): resulting in death) Last igned by the attending physicien be detached for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been sig ; page 2 should t Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Proysciam. I within 24 hours after death.

To the Funerel Director. After this certifica completely filled in by the funeral director; æ 25. Was case referred to medica 26. Place of Death (Check only one) 1 🗌 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a SYED ABBAS MD EDAR

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per doc g935 1-7-13 yt. State of Maryland / Department of Health and Mental Hygiene 2 1 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Steven Johansen, Sr. 2012 Medical December 11:04 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 23935 Carrlyn Drive Ridgely Caroline Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Director 219-18-1180 1X M 2 D F Yrs. 87 Sept. 15,1925 New York 10h County ?7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland 1 Yes 2 No Caroline Ridgely 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23935 Carrlyn Drive 21660 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give 3 

Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I of Health and Mental of Health and Mental fitem 27 is marked ပ Unknown Lucy Paz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie Fessler/ Daughter 23935 Carrlyn Drive, Ridgely, Maryland 21660 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of H Important: If ite any Injury or ot Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Glen Haven Mem. Park | 01/03/2013 | Glen Burnie, Maryland 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 21. Sig ature Funeral Se Licera 6 Crain Hwy, SE, Glen Burnie, Maryland 21061 421 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown P.O.1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 1 Yes 2 Ro 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autons performed? Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Home 5 K Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b title 31036 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

			Please amend	Type or Print in E #19a&b Per ANA 8 State of Marylan 8 amend #20a-c	Black Indeli	ble Ink. Ensure 5 1/07/2013	All Copies	s Are Legibl	e.					
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-	Examin	er	4a. Facility Name (if not institution, give	street and number)	4b. Ci	ty, Town, or Location of De	ath	4c. County of D	eath					
	Funeral		5. Social Security Number 6. S	/ / / / / / / / / / / / / / / / / / / /	Montgo	Birthplace (State or Foreign								
	Director		253-16-0132 1 Usual Residence of Decedent	MM 2 DF 94	Yrs. Month	s Days Hours Mi	03//2/07		th Carolina					
	/land f show	tor	10a. State 10b. County	10c. City	, Town or Location		1- (1-	C C C C GOOD	10d. Inside City Limits					
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	with th	Funeral	2700 BARKE	ER ST	11.	Zip Code	ł	10g. Citizen of What	Country?					
	items items		11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		edent of Hispanic Origin? ( ecify Cuban, Mexican, Pue	Specify Yes or No-		merican Indian,					
36	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho nate. Extrainer must be notified at	d by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give		2 No Specify:	rto nicari, etc.)	Black, W Specify:						
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Mar	2 shoulth and 27 is m		19a Informant's Name/Relationship (To Sabrina Emory—	randdaughter	4	ISTO DRNumbor			100					
	ge 1 and it of Heal it item; or other		20a. Method of Disposition	20b. Pl	lace of Disposition (N	ame of	Date Date	20c. Location - City	or Town, State					
Baltimore	nit. Page vartment o ortant: If injury or e.		1 ☐ Burial 2 ☐ Fremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State Att	emetery, crematory of antic Cre	matory 1/1	6/2013	Glen Burn	ie,MD					
Balt	permit. Page Department Important: I any injury or		21. Signature of Fund 15 de Licen Ronald 6	ale, Director	22. Name <b>Simp</b>	and Address of Facility S	tate Anat	emy Beard	Thomas Allen					
			23a. Part 1. Enter the disease, or company of the c	plications that caused the death	n. Do not enter the mo	O Ridge RD H	anover mb	21026 11	Approximate					
Į.	nysician/		shbck, or heart failure. List only o Immediate Cause (Final disease or condition		RENAI	PAILL	RP		Interval Between Onset and Death					
	Medical Examiner		resulting in death)	Due to (or as a consequent	ence of):	, , , , ,								
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Box 68760	ath certificate be attending physici for use as the bu	/edic		d										
39 ×	th certi	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal		c pregnancy		23d. Date of	delivery					
B	requires that the death been signed by the atte should be detached for	by Physician/Medica	1 Yes 2 No 9 Unknown	4 Pregnant at time of de g Unknown				Month Day Year						
<u>о</u> .	that the ned by e deta	y P	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the underlyin	g cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?					
ds,	equires sen sig rould b						1 🗆 '	Yes 2□No 3□	Probably 4 Unknown					
00 00	e law re has be ge 2 sh	Completed					24a. Was autop	osy L prior	autopsy findings available to completion of cause of					
<u>~</u>	in: The ificate or, pag		25. Was case referred to medical			00 00 00	1 🗆 Yes	rmed? death	Yes 2□No					
Vita Vita	nysicia lis cert direct	To Be	examiner?	Hospital:	ER/Outpatient 3	26. Place of Death (Ch Other:		lence 6 🗆 Other (Sp	ecify)					
اه ر	<b>ding Physician:</b> The la h. After this certificate he funeral director, page	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		28b. Time of injury	28c. Injury at work?		ow injury occurred	ocal))					
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	To the within 2 To the comple	≥	only one) 3 ☐ Certifying Nurs  29b. Signature and title of certifier	se Practitioner: To the best of m		9c. License number		he cause(s) and manne 29d. Date signed (Mo						
			· N. /	1che		D 65305		12,30,	2012					
)			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  DR NABILA KHAN 1500 POREST GLEN RD SINGER SREING MD 20910											
	Stat	e	31. Date filed Month, Day Year)	32. Registrar's Sgnati	Ure MI	J RD SILVE	R SPRIA	JG MD	20410					
	Registra	ır	JAN U 7 2013	32. Registrar's Signatu	garre									

			. For	State of					Mental Hyg		,		
			State     Registrar			Cer	tificate of I	Death	F	Reg. No. 2	12 42	991	
	Physicia	n/	Decedent's Name (First, Middle	e, Last)					2. Date of Dea Month			of Death	
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	Examin	er						timore	of Death	}			
100	Funeral		Caton Manor  5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		) Vanel	Birthplace (State Country)	e or Foreign unk	
	Director		248-58-5733	1 🕅 M 2 🗆 F	76	Yrs.	Months Days	Hours Min.	Mar 23		Country)	unk	
	nd now at	_	Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo	cation		1		10d. Inside	City Limits	
	anylar 3a-f s ified	Director	MD			Ba1	timore				1 😾 Y	′es 2□No	
	the Mor 28	اق	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country?		
	filed within 72 hours after death with the Mayland fled within 72 hours after death with them "natural", or items 23a or 28a-f show ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	409 S. Chapel	gate Lane	!			229		U	SA		
	death item ner n		11. Marital Status	lispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		ce - American Indian, ck, White, etc.						
36	after al", or xami	d by	1 X Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Voc Ci	2 ሺ No ve		1 ☐ Yes 2 🛣 No	Specify:		Specify	black		
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anc		10 B	17. Father's Name (First, Middle,	Last)			unk	18. Mother's Na	ime (First, ivildale, i	viaiden Surriain	(6)	unk	
Maryland	2 should be file th and Mental I ?7 is marked o traumatic eve		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Street	and Number or R	ural Route Number,	City or Town,	State, Zip Code)		
	C/ =		Shirley Dean	/friend		180	)5 E. Nor	th Avenu	e Baltim	ore, MD	21213		
Baltimore,	ge 1 and it of Healt it of Healt it item 2		20a. Method of Disposition  1  Burial 2  Cremation	3 Removal from		Place of Dispo cemetery, crer	sition (Name of matory or other pla	ce)	Date	20c. Location	- City or Town, State		
ţį	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other	Specify) /in s	tate								
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				d.	JE d	Dia	400 1	1011			Javes -		
9289	eath certificate b attending physi I for use as the l	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant		23d. Da	ate of delivery							
Вох	death e atte ed for	sicia	in the past 12 months? 1  Yes 2 No		Birth 2 Fet gnant at time of		Cther (specify)			M	onth Day	Year	
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σ.	v requires that t s been signed b s should be deta	d by	Part II. Other significant conditi	ions continuating to	death out not re	Soliting III the C	andonying oxdoo g		1 🗆 🗎	(mh	3 Probably 4		
of Vital Records,	requi been shoul	Completed							24a. Was a		Were autopsy finding	js available	
ecc	The law ate has page 2	d Ho	<u> </u>				<del>-</del>			rmedo 2 <b>X</b> No	prior to completion of death? 1 ☐ Yes 2 ☐ No	if cause of	
a H	sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner?				26. F	Place of Death (Ch		ZUNO	100 20110	<u> </u>	
ΖΞ	Physic this ce ral direc	은	1 Yes 2 No		Inpatient 2		nt 3 ∐ DOA		Home 5 Resid				
on of	ttending P death. ctor: After t y the funera	icate:	27. Manner of Death Natural 5 Pend 2 Accident Invest	/8.4-	e of injury nth, Day, Year)	28b. Time o injury	woi		28d. Describe h	ow injury occur	red		
Division	or Atte after des Director in by th	Certificate:	3 Suicide 6 Could 4 Homicide deter	28e. Plac	e of Injury - At h ling, etc. (Speci		reet, factory, office		28f. Location (S City or Tow		ber or Rural Route Nu	mber,	
Ω	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical	g Physician: To the Examiner: On the ba	asis of examination	on and/or inves	stigation, in my opin	ion, death occurred	d at the time, date a	nd place, and de	ue to the cause(s) and	manner stated.	
	To the within 2 To the comple	Σ	only one) 3 Certifyin 29b. Signature and title of certifie	g Nurse Practitione	ar; to the pest of	my knowleage	29c. Licens	se number		29d. Date signe	ed (Month, Day, Year)		
			1 wygen	or CA	ens		R14	855	1	12.	19.20	12	
	-		30. Name and address of person	who completed car	use of death (Ite		Print) 609	5 Mars	chalce i	Dr, Ell	19.20 Uridge,	MD	
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Sign		1000			0	21075		
	Registr	ar	1881 0.77	2010		A Sugar	A						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ JOHNNA 0815 RRELL 25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANDRIN INPATIENT CARE CENTER HARWOOD Arunde1 Anne 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) Director 221-24-9447 1 🗆 M 2 🔀 F 73 Oct. 7, 1939 Delaware . Page 1 and 2 should be filed within 72 hours after death with the Maryland irnent of Health and Mental Hygiene. tent: If item 27 is marked other than "natural", or items 23a or 28a-f show jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Bear DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19701 USA 433 Sweetman Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Technical Writer Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter C. Jarrell Joanna A. Szewczyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristina J Baker (Daughter) 420 Epping Way Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or of once. 1 Burial 2 Cremation 3 Removal from State Cathedral Cemetery 12-27-12 Wilmington, DE 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Metropolitan Funeral Service 22. Name and Address of Facility 5517 Vine Street Alexandria, VA 22310 24 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, focily, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician/ JEMENT Know Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ELERI Examine Due to (or as a consequence of): ed by the attending physician and detached for use as the buriel-transit Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown r this certificate has been si-aral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) MICC 1 Inpatient 2 ER/Outpatient 3 DOA ျဉ within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending injury Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 125 65 evs 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death December Physician/ II, 2012 7:17 AMM Sarah Kincaid Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Aberdeen 100 Hamilton Place 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 215-68-7322 1 🗆 M 2🗓 F Nov 28, 1957 Florida 55 Usual Residence of Decedent works permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matring at 10c. City, Town or Location 10d. Inside City Limits 10b. County Director MD Harford 1 Yes 2 No Aberdeen 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 100 Hamilton Place Funeral 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed 3 Divorced 4 X Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) cosmotologist health and beauty Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruth Madron 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Bichy/daughter 209 Foxhall Drive Bel Air, MD 21015 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify) in state we of Euneral Se Ronal 22 Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death the Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed. death? 1 ☐ Yes 2 ☐ No Yes 2 No this certificate Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 읻 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: after death. Director: After work?
1 \( \sum \) Yes 2 \( \sum \) No 1 Natural injury 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 29c. License number 20018 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601.5. ave NAIR, MO KARMA-S Umia

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 7 2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ December 7:09 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Regional Hospital Laurel Prince Laurel (reorge's If Under 1 Year If Under 24 Hrs Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) 216-60-9485 Director 1 ☑ M 2 ☐ F Yrs. Washington, DC or items 23a or 28a-f show 10b. County 10c. City, Town or Location Director Examiner must be notified MD BURNI 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PNWOO U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 2 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify. 3 Widowed 4 Divorced Black Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) COMPany Be 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) ( Mady S mother 20b. Place of Disposition (Name of 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee FUN. eral 10 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Severe Physician/ Sepsis disease or condition resulting in death) Medical Examiner Theumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury Hospital or Attending Physician. The law requires that the death certificate be executed that initiated events resulting in death) Last Difficile Infection Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed death? 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 2 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, . Manner of Death 1 D Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature :

31. Date filed (Month, Day, Year)

nd title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print), George I. Okang, MD Laurel Regi

Laurel Regional Hospital

D41248

January 2, 2013